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ABSTRACT

The Better Care for the Babies (BCTB) Project was initiated in April 1989 to help states improve the quality of infant and toddler child care, especially for low-income children whose parents are in the labor force and/or making the transition from welfare to work. The BCTB Project initiated ongoing, negotiated, goal-directed technical assistance with three state interagency teams in Florida, Illinois, and Utah; conducted a national technical assistance forum; and implemented national outreach through the preparation and dissemination of policy papers. The chapters of this case study describe the background and design of the project, the policy context and assumptions, the technical assistance approach and implementation, project actions and policy improvements related to child care quality made by the BCTB states, the project as perceived by key participating state administrators themselves, lessons learned, and recommendations. The recommendations focus on federal mandates that would include incentives, offering states goal-directed technical assistance, coordination of state policies and programs, and conveyance of information to state leaders concerning the influence of child care on child development. An appendix lists 15 Better Care for the Babies policy papers and briefings issued between 1990 and 1993. (Contains approximately 65 references.) (JDD)

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Lessons Learned: Provision of Technical Assistance to States

Better Care for the Babies Project

ZERO TO THREE

National Center for Clinical Infant Programs

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ZERO TO THREE/National Center for Clinical Infant Programs (formerly the National Center for Clinical Infant Programs) is the only national nonprofit organization dedicated solely to improving the chances for healthy physical, cognitive, and social development of infants, toddlers, and their families.

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CHAPTER I:

OVERVIEW

Introduction

In April, 1989, **ZERO TO THREE,** formerly known as The National Center for Clinical Infant Programs, initiated a program of technical assistance designed to help states improve the quality of infant child care within their borders. Called the Better Care for the Babies (BCTB) Project, this program draws on the resources of **ZERO TO THREE's** board members, staff and consultants, connecting their expertise with the interests of early childhood policymakers at the state level.

In addition to providing technical assistance to help states improve the quality of infant and toddler child care, BCTB was designed to be a source of "lessons learned" about effective approaches to technical assistance and about those elements of technical assistance that match well with both the realities of the policymaking process in selected states and the need to improve the quality of child care. A goal of the project was to analyze and share the lessons learned in a case study.

The funders for the project were motivated by the following:

- the lack of federal interest in the quality of child care;
- the desire to explore different models of providing technical assistance;
- the use of interagency collaboration in efforts to better meet the needs of children and families;
- the expectation that there would be new federal funding for child care that would include efforts to improve quality accompanied by new forms of technical assistance; and
- the desire to explore ways to improve quality even before the arrival of any new federal funding.

Organizational Capacity

ZERO TO THREE is a national organization dedicated to improving the chances for healthy physical, cognitive and social development of infants, toddlers and their families.

The work of **ZERO TO THREE** includes:

- developing training programs and materials that enable professionals representing diverse disciplines to share expertise and learn interdisciplinary, state-of-the-art approaches to promoting optimal health and development in the first three years of life;
- providing technical assistance to administrators at state, community and program levels on approaches to improving the effectiveness of services for infants, toddlers and their families; and

- educating policymakers and the general public about the complex needs of today's infants, toddlers and their families, through publications, seminars and conferences.

Established in 1977 by a small group of distinguished professionals in the fields of health, mental health and human development, this national organization centers much of its efforts around knowledge dissemination and exchange. The BCTB project staff, advisors and consultants are listed in Appendix A.

The BCTB project, like many others at **ZERO TO THREE**, was designed to build on this informational strength and to extend a hand in partnership to state policymakers, offering the resource of knowledge as the principal **ZERO TO THREE** contribution to this partnership.

Nature and Purpose of the Better Care for the Babies (BCTB) Project

The project's major goal is to help state administrators improve quality in infant child care, especially for low-income children whose parents are in the labor force and/or making the transition from welfare to work. The components of the BCTB project, aimed at accomplishing this broad goal, include:

- on-going, negotiated, goal-directed technical assistance with three state interagency teams (in Florida, Illinois and Utah);
- a national technical assistance forum sponsored by **ZERO TO THREE**;
- national outreach through the preparation and dissemination of policy papers; and
- the preparation and dissemination of this case study.

Although quality improvement in infant child care is the overall policy goal mutually agreed to by both the national BCTB team and the three states selected for technical assistance, the states agreed to two subgoals: to increase opportunities for (1) training of infant/toddler caregivers, and (2) participation in immunization and preventive health care for infants/toddlers in child care in that state.

Nature and Purpose of the BCTB Case Study

The case study describes the assumptions that went into the design of the project, reflects on the technical assistance approaches used during the first three years, the state policy improvements perceived, observed and documented and the relationship (if any) between these policy improvements and the technical assistance provided by the BCTB project. It then reports on the lessons learned about the assumptions and the technical assistance process and makes recommendations regarding technical assistance and the improvement of infant and toddler child care services. It is not intended to be a formal evaluation of the project.

ZERO TO THREE, the Better Care for the Babies Project offers "goal-directed" technical assistance to state administrators, particularly (but not exclusively) in three states: Florida, Utah and

Illinois. Goal-directed technical assistance is defined as knowledge transfer and exchange designed to encourage and help policymakers reach a policy goal mutually agreed to by the policymaker and the technical assistance provider. The strategies for reaching this policy goal are negotiated and put into the form of a written, evolving letter of agreement.

The knowledge transfer (from the BCTB staff and consultants to the states) and exchange (from the states to the BCTB staff and among the states) spans a wide range and includes information about:

- sources of federal financing useful to quality improvement in infant child care;
- quality improvement strategies adopted or being demonstrated in other states;
- federal policies relevant to quality improvement; and
- research findings and expert opinion relevant to quality improvement.

The Better Care for the Babies project began in April, 1989, and will continue through 1993. The case study covers activities from 1988 (when the project was conceptualized) to the end of the third year of project activity in April, 1992.

Audience for the Case Study

We hope that the lessons we have learned will be useful to:

(1) leaders in the child care field who are either struggling to develop and provide technical assistance to state policymakers or who want to further develop their own knowledge of state policymaking processes and the interaction of goal-directed technical assistance with those processes;

(2) funders in private foundations and federal agencies who want to develop and/or support technical assistance to help states improve child care quality or who want to help existing grantees who may feel they are struggling with the challenges of such technical assistance in an isolated fashion;

(3) policymakers at the federal level who want to design or implement child care legislation in such a way that quality improvement in child care is fostered; and

(4) state administrators and legislators who are interested in learning more about strategies that other states develop and adopt to improve quality or who might want to seek technical assistance from a national organization working with states on quality improvement strategies.

The audience for the case study is seen as a relatively small and motivated segment of the policy community concerned with child care—in Washington, DC, in state capitals, and in the offices of private foundations and other private sector supporters of quality improvement in child care.

Summary of Lessons Learned

After three years of planning and providing goal-directed technical assistance to state policymakers, the Better Care for the Babies Project staff have concluded that goal-directed technical assistance should be one of the quality improvement strategies that federal policymakers are required to offer states.

Briefly, the nine lessons learned are as follows:

- Goal-directed technical assistance depends on flexibility of approach and the dynamics of political and human relationships and therefore, may not lend itself to quantitative evaluation.
- A strong commitment from state and federal policymakers to integrate separate funding sources at the state level is necessary to improve the quality and comprehensiveness of infant and toddler child care services.
- Access to the governor's office is not sufficient to improve services.
- It is important to focus on areas of agreement.
- Matching information provided by technical assistance to state needs is critical.
- Information needs to be personalized, targeted, useful and provided in a variety of ways.
- Technical assistance should be flexible and negotiated.
- Collaboration demands time and commitment and is a delicate process.
- The child care income disregard program, for families receiving public assistance and not eligible for Family Support Act assistance, must be a focus for attention.

Recommendations

The case study concludes with six recommendations that we hope will help other providers of technical assistance, policymakers and administrators at the local, state and federal levels, foundation officials and corporate leaders interested in improving the quality and comprehensiveness of child care services for infants, toddlers and their families. Summary statements related to the recommendations follow.

1. The Child Care and Development Block Grant (CCDBG), Family Support Act (FSA) and Title IV-A At-Risk Child Care Program should include expanded allowances and funding to address quality improvements in the reauthorization process.

2. Federal mandates and funding are needed to improve the quality of infant and toddler child care services.

3. The mandates need to be new types that include incentives and that will work for the 1990's.

4. Goal-directed technical assistance should be one of the services offered to states to accompany mandates and/or incentives.

5. Funders of technical assistance should support approaches that convey information on the influence child care has on the development of infants and toddlers to the attention of state leaders in a policymaker-friendly, understandable manner.

6. There should be state and federal mandates and funding to coordinate state policies and programs to improve the quality of infant and toddler child care services.

The following chapters describe:

- the background and design of the project: the policy context and assumptions;
- the goal-directed technical assistance approach and implementation, including the rationale for selecting each of the three participating states;
- project actions and policy improvements related to child care quality made by the BCTB states (1989-92), and the project as perceived by the key participating state administrators themselves; and
- our findings and the lessons learned along with our recommendations.

CHAPTER II:

PROJECT DESIGN

National Demographic and Policy Context: The 1980s

In the 1980s, escalating need for child care collided with rapidly declining federal support for child care. During this period, economic conditions deteriorated for low-income families, including working poor families (those families with a strong tradition of commitment to self-sufficiency, but whose wages are so low that family members still live in poverty). In 1979, a minimum wage earner working full time lifted a family of three out of poverty. By 1988, the minimum wage had declined 33% in real terms using 1979 as a base. By 1989, the same family's income was 30% below the poverty line (Select Committee on Children, Youth, and Families, 1989; Children's Defense Fund, 1991).

Families headed by adults under 30 years of age were hit particularly hard. By 1990, in contrast to 1973, a child in a family headed by one parent under age 30 was twice as likely to be poor, and two-and-one-half times as likely to be poor if living in a family headed by two parents under 30 (Edelman, 1992). By 1989, nearly 13 million children lived in poverty, an increase of 2 million over the previous decade. Nearly 5 million lived in families with incomes below half of the poverty line. Of preschool children, nearly one in five lived below the poverty line. Nearly one in four infants and toddlers lived in poverty (National Commission on Children, 1991).

Families with children under three found it particularly difficult to produce enough income to maintain stable living conditions. By March, 1988, more than 56% of mothers of preschool children—and more than 51% of mothers of infants—were in the labor force. Between 1976 and 1987, the labor force participation of mothers of infants aged one year and younger rose from 31% to 51% (Select Committee on Children, Youth, and Families, 1989; Children's Defense Fund, 1991). In addition:

- **There were severe cutbacks in state financial support for child care for the working poor.** Twenty-eight states redirected Title XX funds that had been spent on child care, spending less for child care in 1987 than in 1981, when adjusted for inflation (Center for Budget and Policy Priorities, 1988, and Children's Defense Fund, 1987, in Select Committee on Children, Youth, and Families, 1989).

- **There were severe cutbacks in the number of children served by publicly supported child care.** By 1987, twenty-three states were serving fewer children than in 1981, despite increased need (Center for Budget and Policy Priorities, 1988 and Children's Defense Fund, 1987, in Select Committee on Children, Youth, and Families, 1989).

- **There were precipitous declines in center-based toddler child care quality, particularly along the measures of staff-child ratios and caregiver stability.** In 1976–77, actual observed staff-toddler (18 to 36 months) ratios were almost 1:6, despite expert recommendation of a 1:4 ratio for children in this age group (Ruopp, Travers, Glantz and Coelen, 1979). In 1990, while reported staff-toddler ratios still hovered at six or seven toddlers per caregiver for groups of 1-year-olds only, groups of two-year-olds had seven to eight toddlers per caregiver—almost double the expert recommendations made more than a decade previously. Worse still, these toddlers could not even count on one adult being there for the whole year: staff turnover had escalated from 15% in 1976–77 to 41% in 1989 (Ruopp, Travers, Glantz, and Coelen, 1979; Whitebook, Howes and Phillips, 1989).

The economy, the decline in real terms of purchasing power, the increase in the divorce rate, the decrease in the marriage rate, and the rising birth rate contributed to the increase in child poverty. These and other factors produced real tensions for families with very young children. These tensions were compounded when the federal government cut the major source of child care funds, Title XX of the Social Security Act, and folded it into a much reduced Social Services Block Grant (SSBG) where social services were pitted against child care services at the state level.

In addition, there were severe cutbacks in the principal source of federal financial support for child care for parents making the transition from welfare to work. Federal outlays related to the Aid to Families with Dependent Children (AFDC) child care disregard fell from $120 million in FY 1980 to an estimated $40 million in FY 1988 (Select Committee on Children, Youth, and Families, 1989).

The Family Support Act (FSA) was enacted in 1988, but not implemented until 1990. This federal legislation was designed to encourage labor force participation (or preparation for employment) rather than welfare dependency. It held out the promise of new federal funds, which would have to be matched by states, for child care for those making the transition from welfare to work. However, it did not address the child care needs of the working, non-AFDC, poor.

Increased federal funds for child care for working poor and blue collar families did, however, become the subject of intense debate in Congress during the late 1980s. With the introduction of the Act for Better Child Care (ABC) services, which later evolved into the Child Care and Development Block Grant (CCDBG), and during the Congressional debates, it seemed clear that there would be additional funds for child care. However, it was far less clear that any federally specified standards related to quality would be required as a condition for receiving these funds. Such measures were opposed by a coalition of groups. Regulatory approaches to quality improvement were also opposed by the White House.

In the early 1990s, the administration favored expansion over quality improvement in its public and private struggles with Congress during the Head Start reauthorization process. The Congress, supported by a Head Start constituency, had prevailed and obtained quality improvement provisions in the bill. However, in the child care legislation, the reverse occurred. The constituency for the child care legislation disagreed about several issues, including quality improvement. In 1990, as one condition for White House support of the first federal, separate legislation for direct child care grants to the states, the administration won substantial concessions that diluted the quality improvements of the original ABC bill.

Thanks to a massive campaign by child care advocates across the country coordinated by the Children's Defense Fund, key Congressional leaders and the ABC Alliance helped with passage of the 1990 landmark child care legislation, which set authorization levels at above $1 billion annually for child care grants to the states. Three sources of child care funds were created: the Child Care and Development Block Grant, a system of young child earned income tax credits and the Title IV-A At-Risk Child Care Program. These sources all helped to increase the availability of financial assistance to eligible families, but only the Child Care and Development Block Grant law built in funding specifically for quality and early childhood development and coordination.

This preference for expansion over quality improvement emerged again in proposed and interim final federal regulations governing the use of these new child care funds. All of the federal regulations developed for the states by the Department of Health and Human Services (DHHS) emphasized expansion of the supply of services, not quality improvement. In fact, interim and proposed federal regulations put obstacles in the paths of states, some of which were determined to protect the level of quality they had obtained before the new legislation. Many states that were committed to improving quality in publicly funded child care were severely limited, not by the laws, but by the proposed and interim final rules.

Incentives states had used (such as higher reimbursement rates) to urge people offering child care to adhere to health, safety and other standards related to quality were forbidden by these rules. Under Title IV-A At-Risk Child Care differential rates were allowed (tied to a market rate). Under the CCDBG, differential rates were not allowed (and not tied to a market rate). Under IV-A At-Risk, even immunization was not to be required, nor were child abuse screenings for child care providers—unless as part of a whole array of licensing requirements that would apply to all people caring for children. This forced states that had laws exempting family day care (and other forms of care) from licensing requirements to regulate everything or make no improvements. Exempt care providers were to be paid at the same rate as those family child care providers who had spent time and invested money in becoming licensed or registered (regulated). This put state administrators, who were attempting to blend these sources of funds, into the position of having to face paying higher rates (thus costing more in state match, for the IV-A portion) for lower quality, and left no incentives for child care providers to gain or maintain a license or registration. These were steps most states were not prepared to take.

In addition, the CCDBG interim final rule severely limited the percentage of funds that could be used for quality improvement. States could use only a combined set-aside of 5% of the total funds plus up to 15% of the 75% set-aside for direct services for administration and/or quality improvement.

The Proposed Rule for Title IV-A At-Risk Child Care particularly endangered very low-income infants and toddlers, who so often are in unregulated ("license-exempt") family child care. It prohibited any extension of health and safety protections, even though the final rule for Title IV-A Supportive Services, which pays for child care related to the JOBS program authorized by the Family Support Act, encouraged states to "endeavor to create standards" for family day care. Trying to figure out how to manage contradictory, not final, rules so they would benefit children and families and not weaken the level of care was close to impossible and put an extremely high level of pressure on state administrators for the period between June 1991 and August 1992.

In response, a new national campaign was mounted to change both the IV-A At-Risk Child Care proposed and the CCDBG interim final rules. The final rules removed some of the obstacles to quality improvement. The Title IV-A At-Risk rule allowed states the option of "denying payment to child care providers who do not meet health and safety standards" required of other state or federally funded child care services. They also very slightly modified the ban on differentiated rates, allowing up to a 10% differential after meeting administratively taxing federal conditions. However, for over a year, the proposed and interim final rules had promoted an administration position against quality improvement—chilling initial state policy planning for the implementation of the new federal child care

funds. This chilling effect also impeded state and BCTB progress toward their central goal: quality improvement in infant child care.

Rationale: The Needs Addressed by the Project

At the project's inception, BCTB staff reviewed the literature related to quality and infant child care and drew five conclusions:

1. **Quality was so inadequate in some infant child care services that infant and family well-being was likely to be damaged.**

   a. We know how to provide high-quality infant child care. It is both similar to and different from high-quality care for children aged three and over and has the following six key elements:

      - a skilled and knowledgeable caregiver with specialized infancy-related training (Whitebook, et. al., 1989);
      - a stable child care arrangement that includes the presence of a consistent caregiver trusted by the child who responds to the child's individual personality and needs (Cummings, 1980; Howes and Stewart, 1987; Rubenstein and Howes, 1979; Suwalsky, Zaslow, Klein and Rabinovich, 1986);
      - a family-centered approach (Powell, Weissbourd, and Zigler, 1987);
      - support for the child's and family's participation in preventive health care (Granoff and Cates, 1985; Jarman and Kohlenberg, 1988);
      - placement of a very small number of children continuously (or as continuously as possible) under the care of a primary caregiver (Ruopp et. al., 1979; Whitebook et. al., 1989); and
      - a safe and developmentally appropriate physical environment (Aronson, 1983).

   b. The degree of quality has a powerful influence on infant and toddler experience in child care. A meeting of top researchers, sponsored by **ZERO TO THREE** and chaired by Board member Edward Zigler, Ph.D., concluded in 1987 that, when freely chosen by parents, good quality infant child care is highly likely to be an environment in which infants and toddlers can thrive (**ZERO TO THREE**, undated). Increasingly convincing evidence demonstrates that high-quality, family-centered care and education services for low-income children under three might well improve outcomes for both children and mothers (Lally, Mangione, Honig and Wittner, 1988; Seitz, Rosenbaum and Apfel, 1985).

c. On the basis of the available evidence, quality in infant and toddler child care generally has been so poor that it might well compromise infant health and development (Divine-Hawkins, 1981; Ruopp et. al., 1979; Szanton, 1989; Whitebook et. al., 1989; Young and Zigler, 1988).

2. Economically disadvantaged infants and their families were more likely to experience poor quality child care services.

At the time, little research evidence comparing the quality of middle-income and low-income infant child care was available. However, substantial evidence pointed to severe damage during the 1980s to virtually all of the supports to quality care available for low-income families: funds, standards, monitoring and training (Blank, 1983, 1984, in Kahn and Kamerman, 1987; Blank and Wilkins, 1985, 1986, in Kahn and Kamerman, 1987). As we designed BCTB, child care leaders at the grassroots level told us repeatedly that the stripping away of these quality assurances, particularly during the Reagan years, had contributed to inadequate quality in child care for low-income infants and toddlers (Pizzo, 1988).

Much of the infant/toddler child care available to welfare recipients while they were working their way off welfare, or enrolled in pre-JOBS programs was reportedly unstable and often without any consumer protection or public oversight. The amount of funding, having to pay "up-front" child care costs and the method of using child care costs as a portion of a family's AFDC grant for welfare recipients using the child care income disregard, essentially forced people to find the least expensive child care. In addition, those working poor who were not on welfare often did not have access to subsidies, either because states had waiting lists (no money) or because information about financial assistance was not widely available.

Despite the enactment of the Family Support Act (FSA), which intended to help both parents (through training and education) and children (through stable child care), the Child Care and Development Block Grant and the IV-A At-Risk Child Care Program, states were faced with balancing the need for child care slots against essential quality improvements. Until September 7, 1991, there were few federal funds to plan quality improvements.

3. State policymakers had expressed a need for information regarding promising or proven approaches to improving quality in infant child care.

From 1987 to 1989, supported by the Mailman Foundation, **ZERO TO THREE** conducted a pilot infant child care quality improvement project called State Agency Approaches to Improving Day Care for Infants and Toddlers. Support from Mailman permitted us to interview state administrators with responsibility for infant child care in key states around the country.

In 1987, we convened a focus group of state administrators from five states. Both the interviews and the focus group confirmed that state administrators—caught between the escalating demand for infant child care and the organized opposition of some groups to infant child care—had even less time than usual to concentrate on learning about workable strategies for quality improvement in use in other states.

4. State child care administrators and state administrators concerned with identical or similar populations of infants, e.g., served by maternal and child health administrators and early intervention services administrators, often were isolated from each other.

During the years 1986–1989, **ZERO TO THREE** conducted Project Zero to Three, a 15-state technical assistance project in early intervention services for infants and toddlers with special needs.

Teams of parent leaders, as well as state administrators from different agencies within each of the 15 states, met to plan statewide systems of early intervention services. It became clear to **ZERO TO THREE** staff that child care administrators were typically not involved in this policy planning at the state level.

In 1988–89, as we designed the BCTB project, we interviewed state child care, maternal and child health and early intervention services administrators in 12 states specifically for the purpose of selecting three states to participate in BCTB. Isolation of the child care administrator from the early intervention/Part H administrator was common. In addition, despite the immunization crisis and the acute need for disease prevention and health promotion in infant child care, state child care administrators in the states we surveyed often had very little contact with the state maternal and child health administrator (**ZERO TO THREE**, 1990).

5. There was inadequate understanding about state policymaking among national leadership in the field of infant child care services.

During the period from 1970 to 1985, much of the attention of child care leaders at the national level had focused on Washington, DC, and on federal policy. Decisions in Congress, the White House and in federal agencies were studied and written about, so that child care leaders could develop their understanding of federal policy and policymaking.

Of course state policymaking was never totally ignored by national leaders in child care and was certainly a focal point for the growing numbers of skilled child care leaders within each state. However, the Reagan cutbacks influenced national leaders to join forces with state child care leaders to protect both the quantity and the quality of child care. Child Care leaders supported states who were making a beginning or increasing their commitment to child care on their own, in spite of the federal cutbacks.

As BCTB was designed, we consulted with national child care leaders about the need to better understand the state policymaking process. Many felt that policy formation at the state level was not well understood by national leaders in child care (Pizzo, 1988; **ZERO TO THREE**, 1990).

Given our conviction that in the foreseeable future policy change supportive of quality improvement in child care would be more likely to occur at the state than at the federal level, we believed that there was a need to improve both our own and the field's understanding of state policy-making processes.

Philosophical Framework

The following points provided the scaffolding for the BCTB project in its design stage:

1. Emphasize a family-centered approach to infant child care.

Family-centered child care is care and education co-designed by parents and providers working in partnership. The caregiver offers parents opportunities to strengthen their skills as nurturers, educators and/or advocates for their own children, and she, in turn, is prepared to learn from parents (Pizzo, 1990). To be family-centered, infant child care should be concerned with the development and empowerment of parents (i.e., biological parents or those who take major parenting responsibility) as well as the development and well-being of infants and toddlers. Services are structured not just to care for the child in the day-to-day absence of the parent, but to promote the parent-child relationship (Galinsky and Weissbourd, in press).

2. Emphasize a whole baby approach to infant child care.

An infant's development is inextricably linked to his/her health—and both are intimately related to mental health. Furthermore, while not all infants are at risk of developmental delay, all infants have individual needs, arising from unique temperaments, innate differences, and differences in family circumstances, values and cultures.

Thus, infant caregivers require special skills and knowledge in order to be attentive to the overlapping domains of development—to an infant's health, emotional well-being and developmental needs. Caregivers must also know about and be able to respond well to both typical and atypical development.

3. Emphasize quality improvement, rather than primarily the expansion of the supply of infant care.

BCTB was designed with the assumption that the 1990s would experience a significant expansion of federal support for child care services. However, we also believed that unless an alternative was consciously promoted, the historic policy tendency to emphasize supply expansion rather than quality in child care for the working poor would prevail. Expansion of poor quality, inexpensive infant and toddler child care would then be the possible result of this expansion of federal funds.

We felt that twenty years from now experts will have shown that the critical juncture in the history of infant child care in America occurred in the 1990s. This would be the time when policy change supportive of high quality mattered most.

4. **For quality improvement, plan ahead for implementation of new federal funds specific to child care and Head Start.**

In 1985, **ZERO TO THREE** helped research and write, as part of the Ad Hoc Day Care Coalition (a group of 25 national organizations), a position paper analyzing the shortage of infant/ toddler child care. Called The Crisis in Infant and Toddler Child Care, this position paper urged that expansion of infant child care services and the enhancement of its quality be undertaken.

As we planned the BCTB Project, it appeared likely that some form of additional federal funds for child care would be enacted by the Congress, although it was not yet completely clear whether these funds would predominantly take the shape of direct grants to states or tax credits to individuals.

At the same time, expansion of funds for Head Start was clearly going to occur. We believed that some of the early care and education needs of low-income three- and four-year olds would be met at least partly through Head Start expansion. Given the crisis in infant and toddler child care supply, we anticipated that at least some of the new child care funds would be used for infant care.

Design of Technical Assistance Approach

1. **For quality improvement, plan to blend health, early intervention and Medicaid funds with child care.**

We anticipated that promoting more comprehensive services to infants in child care (including family support, strong linkages to preventive health, mental health and early intervention services if needed) would be met with cost objections.

The full cost of good quality center-based child care for preschoolers is estimated to be between $6,364 and $8,345 annually (Willer, 1990). Although reliable estimates on the full cost of good quality infant child care are not yet available, it will undoubtedly be higher than these figures. Good quality infant child care requires more trained staff, smaller groups and fewer children assigned to one caregiver than older children require.

Our plan, then, was to look for sources of federal funds that states might tap to promote both family support and linkage to early intervention and health services in infant child care. Between 1986 and 1989, as the BCTB project was being designed, Congress did enact new entitlements (or expanded existing entitlements) for infants and their families in the health, welfare-to-work child care and early intervention services areas. Some of these new entitlements were funded with an open-ended federal match (e.g., Medicaid-approved services and supportive and transitional services funded by the Family Support Act) and some with domestic discretionary grant-in-aid funds, which have to be appropriated each year [e.g., Part H of the Individuals with Disabilities Education Act (IDEA)].

Because of the federal budget crisis, the BCTB project was designed with the belief that the largest steady expansion of federal financing for infant health, early intervention and child care services would take place through entitlement programs, such as Medicaid, rather than through domestic discretionary programs whose funds had to be appropriated each year. Particularly when intertwined with Medicaid, we believed that the new child care funds would be a significant source of support for whole baby, family-centered child care.

2. For quality improvement, focus on the state capital not the national capital.

Despite the activity in federal child care policymaking, we did not believe that a Congress divided over fundamental delivery system issues (e.g., over tax credits vs. a direct grant approach) would be able to develop sufficient consensus to enact mandates to the states to significantly improve quality (e.g., federal child care regulations requiring higher levels of quality). Furthermore, private and public sector opposition to any regulation of child care, particularly family child care homes, was matched by a strong antiregulatory position from the Executive Branch. Our assumption was that a compromise would center on regulations that had relevance to child safety. We also assumed that a federal role of support for nonregulatory approaches to improving child care might be another acceptable compromise. We anticipated therefore some federal support for resource and referral services and for voluntary training as quality improvement strategies.

All of the policy support for quality improvement, however, would center on state, not federal leadership. Thus, for the foreseeable future, the state capital, not Washington, DC, would be the center of power for policy changes related to improving the quality of child care.

3. For quality improvement, focus on some areas of agreement in infant and toddler child care.

At the beginning of the project there was not common agreement on whether infant child care was, in fact, good or bad. There were, however, common views on how best to provide the care. The value of offering training for caregivers and of integrating preventive health and mental health care with infant child care were acceptable to all participants.

A quality improvement project built around voluntary participation by states requires concentration on areas of substantial consensus, particularly in the absence of federal policy mandates. Training, in particular, offered many possibilities for consensus development. To make training a requirement, particularly for family child care providers was—and still is—considered somewhat controversial. However, it is considered less controversial (especially when focused on health and safety/consumer protection issues) than having more stringent infant-caregiver ratios. Thus, we anticipated that state policymakers would be more amenable to forging a consensus around requiring some level of voluntary training.

If requiring training still proved to be too controversial, then a consensus might be developed to expand the opportunities for training offered to all caregivers. Building a career development focus would make this training more attractive to caregivers and provide some incentive to improve their skills and remain within the profession.

4. For quality improvement, focus on matching information to state needs.

State administrators receptive to technical assistance about quality improvement are policymakers who are already committed to the goal of quality in child care. They do not need to be persuaded to adopt this goal. Based on extensive interviews with child care leaders in 12 states, and the experience **ZERO TO THREE** staff had with the Project Zero to Three, we concluded that state administrators need practical information that will enable them to achieve this goal. Some of the information needed includes: ways to finance quality improvements; overall quality improvement strategies in use by other states; and new federal policy developments that support quality improvement. We also knew state administrators wanted funds, research findings backing the long-term cost savings of high quality care, and information about strategies used in other states to improve quality. This information would then be used in the states to build the foundation or take the next steps in the complex child care policy arena. The information itself, the process of exchange, and the reworking of the information to fit the state situation was important.

We also believed that as a national organization, whose board of directors comprised some of the best-known infant and toddler development researchers in the country, we would be approaching state child care administrators with an identity that had both advantages and disadvantages. The disadvantage was that we might be perceived as ivory tower technical assistance providers whose knowledge base only applied to the "unreal" world of research findings. This would make trust and mutual respect more difficult to establish. The advantage was that we could be perceived as technical assistance providers associated with respected scholars who base their convictions about the elements of infant child care quality in research.

5. For quality improvement, adapt and then adopt the early intervention services strategy of technical assistance.

During the 1980s, the U.S. Children's Bureau tradition of providing nationally available technical assistance to states administering federally funded child care services was terminated (Zigler and Muenchow, 1985). However, also during the 1980s, **ZERO TO THREE** staff witnessed first-hand the effectiveness of technical assistance regarding early intervention services for children with special needs in stimulating and supporting quality improvement at the state level. With federal agency support, **ZERO TO THREE** provided (through Project Zero to Three) early intervention-related technical assistance to state administrators and parent leaders. Regular evaluations of this technical assistance by both groups consistently documented both its desirability and its usefulness.

In 1986, when Congress enacted the Education for the Handicapped Amendments (P.L. 99-457), the authorizing legislation explicitly directed the federal Department of Education to fund technical assistance and provided funds for this purpose (**ZERO TO THREE**, 1987). These technical assistance provisions were an addition to—not a substitute for—legal protections for parent and child rights. In addition, the technical assistance services available to Head Start and to special education have been important elements in the improvement of children's services.

We believed (and still believe) that it made no sense for Congress to mandate that technical assistance be available to states for the purpose of improving early intervention services to infants and toddlers with developmental disabilities (or at risk thereof), but not to mandate a technical assistance effort for child care.

Implementation of Technical Assistance Approach

The knowledge and philosophical approach **ZERO TO THREE** has about the status of infants and toddlers in child care, is combined with the interests of state administrators to produce an evolving technical assistance approach, called goal-directed technical assistance.

1. For quality improvement, develop a negotiated and flexible form of technical assistance, tied to overall goals of improving quality.

A central tenet of the BCTB project is belief in technical assistance delivered to stimulate and support progress toward mutually agreed-on, written goals. State child care administrators dealing with the crisis of infant/toddler child care are seeking to provide quality improvement against a tide of public demand for an expansion of supply. As a counter to this pressure, we anticipated that it would be important to limit our technical assistance to areas related to quality improvement. First, there would be unavoidable limitations on our time. Second, our engagement with state administrators around policy planning related to quality improvement would be one more counterbalancing influence that state administrators could use to resist the pressure to focus primarily on supply-building.

2. Encourage collaboration among child care, child health and early intervention state administrators.

While designing BCTB, we planned an interagency approach, which we hoped would stimulate joint policy planning among child care, health and early intervention state administrators; increase the opportunities for infants and toddlers in child care to participate in the full range of preventive and primary health care; and increase the opportunities for caregiver training.

As is the case at the federal level, fragmented and sometimes contradictory policymaking results when multiple, usually not co-located policymakers, concerned about the same population of children, make separate policy decisions. For these and other reasons, collaboration at the state level is strongly encouraged by national leaders in the human service field (Blank and Lombardi, 1991; Kagan, 1991; Massachusetts Early Childhood Advisory Council, 1992; Melaville and Blank, 1991; National Association of State Boards of Education, 1991).

Since federal policy was (simultaneously but separately) expanding support for child health, early intervention and child care services for the same population—very young children—we believed that families would benefit if state administrators concerned with child care, health and early intervention services would collaborate more.

We believed that collaboration would have to be consciously and persistently encouraged. Collaboration takes time, commitment to a common vision and a willingness to make changes.

3. In states chosen for commitment to quality, information would suffice as the chief incentive.

Quality improvement in infant child care depends on policymaker commitment to quality, i.e., "political will" and an increased flow of two key resources to states: funds and knowledge. As an information-rich national nonprofit organization, **ZERO TO THREE** decided to center its efforts on the resource of knowledge. Particularly in an emerging field such as infant child care, knowledge transfer and exchange is needed.

As we designed BCTB, we believed that our primary function would be to supply information to highly motivated state administrators who would then use this information to accomplish and sustain quality improvement.

We believe that the knowledge most useful to good policy development at the state level is guided by:

a. examples of best policy practices, based on interpretation of federal laws and regulations and model practices in other states;

b. examples of best program practices in infant/toddler child care, based on research and expert opinion;

c. the financing available to support improved and more comprehensive services and program practice;

d. current federal laws, regulations and policy guidance related to child care; and

e. future policy directions and trends indicated by current policy proposals at the federal and state levels.

As previously stated, we anticipated that during the years 1988–1992, the federal government would increase the flow of funds to the states, but without a concomitant increase in the flow of information useful to state policy development.

Summary

The BCTB Project was planned at a time when the escalating need for quality infant child care, particularly among low-income employed parents and those making the transition from welfare to work, collided with eight years of federal cutbacks in funds and with federal withdrawal from child care-related technical assistance to states.

Reacting to the crisis faced by many families who lacked both affordable and quality child care, child care leadership nationwide brought about the passage of important new federal laws authorizing funds for child care. However, because some constituencies strongly opposed federal leadership in the child care area, two of these new laws neither required nor encouraged quality improvement in child care funded with these new monies.

The BCTB project's designers hoped to help three states improve quality in infant child care and demonstrate that future federal child care legislation could and should require the federal government to fund technical assistance and make it available to the states. From 1989 to 1992, however, the child care community struggled through federal-level controversies over quality improvement in child care policy, the fiscal crises of the states and the national budget crisis. Thus, the BCTB project, like other national projects providing child care-related technical assistance, faced challenges in pursuing its goals and, in tandem with the selected states, in achieving the objectives of the technical assistance.

Nevertheless, substantial new federal funds have been made available and many policymakers within the three selected are strongly committed to quality improvement. And so, as described in Chapter IV, policy improvements in the three states have been achieved.

CHAPTER III:

GOAL-DIRECTED TECHNICAL ASSISTANCE

The Nature of Goal-Directed Technical Assistance

It is our observation that technical assistance is usually available in one of four modes (or a combination), including:

(1) crisis-oriented, short-term technical assistance;

(2) resource center technical assistance, in which the TA provider is typically available over the long-term, and seeks principally to provide information to help the average client manage the average task more effectively;

(3) didactic technical assistance, in which the TA provider is seen as the teacher, available at prearranged times to provide specific recommendations for a particular problem, often on a short-term basis; and

(4) facilitative technical assistance, in which the TA provider is seen as a group leader (or co-leader) in a group of client/problem-solvers, is available to the group at prearranged times and seeks to encourage client-to-client information exchange and mutual problem-solving.

Goal-directed technical assistance shares some of these features, but has distinctive characteristics as well. As previously noted, we have defined goal-directed technical assistance as knowledge transfer and exchange designed to encourage and help policymakers reach a policy goal mutually agreed to by the policymaker and the technical assistance provider.

This type of technical assistance seeks to create a partnership with clients, with shared pursuit of a common goal as the basis for the relationship. It is highly oriented to problem-solving; the problems can be identified by either partner, but it is typically more effective to respond to problems identified by the client.

Providers of technical assistance involve themselves in a mixture of didactic, facilitative and, when necessary, crisis-oriented technical assistance over the long-term, to help clients resolve problems that impede accomplishment of the shared policy goal. Problems unrelated to the shared policy goal are not the focus of goal-directed technical assistance.

Thus, while this form of technical assistance tries to (1) remain flexible to variations in learning and problem-solving styles and (2) adapt, when possible, to policy crises, it is a highly focused form of technical assistance. Once the policy goal is agreed to, it becomes the focal point of all decision-making about technical assistance provision.

Reasons for the Choice of Goal-Directed Technical Assistance

Goal directed technical assistance was chosen as the project's main modality for the following reasons:

1. **Effective policy development related to child care quality improvement (and therefore effective policy-focused technical assistance) requires goals, objectives, strategic planning and commitment.**

Social scientists have long noted the importance of focus—goals, objectives and priorities—and of strategic planning in policy development, particularly that affecting the wide range of concerns related to children and families (Brewer, 1983; Steiner, 1976, 1981; Valentine and Zigler, 1983). Experienced analysts of federal and state child care policy note that the very diversity of the many existing policy goals for child care makes overarching goal development a particularly essential element of effective policy development for child care (Morgan, 1983).

Furthermore, all human services touching the lives of stressed families are themselves vulnerable to multiple crises. Child care—particularly for low-income employed parents or those making the transition from welfare to work—is one such human service. The newness, growth and underfunding of child care make it especially likely to experience repeated crises.

Incorporating a focus on goals into technical assistance to state policymakers: (1) counter-balances the constant pull toward crisis management; (2) supports policymaker involvement in comprehensive goal development and strategic planning; and (3) protects the TA provider from fragmentation and subsequent ineffectiveness as a steady support to policymakers.

In addition, the very process of developing and agreeing on the shared goal stimulates the sorting-through process that characterizes good policy development (Brewer, 1983). If skilled leaders guide the sorting-through process and the problems addressed are tractable, consensus development around a goal will also stimulate long-term group commitment.

2. **Effective technical assistance designed to foster child care quality improvements requires both stimulus and support to policymakers; goal-directed technical assistance incorporates both features.**

In policy arenas characterized by intense, value-laden divisions and chronic, profound underfunding—such as child care and, in particular, infant child care—technical assistance should rely on a combination of stimulus and support to policymakers.

Stimulus is needed because change takes time. In public policy this may be due to the reliance on precedence, inertia that can occur in policymaking bodies, reactive tendencies in often underfunded government agencies and departments, turnover in appointments and the lack of turnover of the majority of government workers, and, in some communities, persistent patterns of discrimination against some groups of people.

Support is needed to address:

- the lack of opportunities for policymakers to interact with other innovators and with well-informed individuals who center their professional lives on the development of ideas and the gathering of knowledge;
- the lack of opportunities to learn about new policy strategies being tried in other states;
- the isolation of policymakers between states and between agency heads within the states; and
- the negative criticism, and absence of validation encountered by policymakers.

Key Characteristics of the Technical Assistance Approach

Six elements characterize the technical assistance approach of the BCTB project:

1. Use of the governors' offices.

The project was designed to go through the governors' offices in order to elicit on-going, high-level interest and cross-agency support in the efforts to improve the quality of care infants and toddlers were receiving in child care.

2. Choice of states.

We chose states based on the following five criteria:

(a) geographic and cultural diversity;

(b) large concentrations of low-income infants and toddlers and apparent use of/need for infant child care by low-income employed parents and those making the transition from welfare to work;

(c) a critical mass (at least three-to-four high-level administrators in the state's executive branch) who in preselection interviews voiced commitment to improving infant child care quality in general, and, specifically, to improving infant caregiver training and/or to improving the access of infants and toddlers in child care to preventive health services;

(d) key executives at the highest level (the governor's office or a near-surrogate) who voiced a commitment to remain actively involved with the project during its entirety; and

(e) a policy climate ripe for well-developed child care quality improvement initiatives (e.g., evidence of recent gubernatorial or legislative decisions supportive of child care).

From recommendations made to us by child and family policy leaders throughout the country, we developed a list of 12 possible states. We then used a telephone interview process that included:

(a) three rounds of in-depth telephone interviews with two to six administrators in each of the 12 states; and

(b) an informal interview focusing on the depth of state interest in and probable commitment to participation in this project.

We also reviewed, using the same focus, policy-relevant documents sent to us by other states interested in participating in the project.

We then chose the following three states:

- Florida, chiefly for its existing progress in and commitment to statewide training for child caregivers and to a more seamless system of services for at-risk infants and toddlers;

- Illinois, chiefly for the strong public/private partnerships within the state, the commitment of key officials in the governor's office at the beginning of the project; and

- Utah, chiefly for its interest in developing increased training opportunities and its existing strong policy commitment to preventive and primary health care outreach.

3. Three state profiles.

Table 1 on the following page, shows key demographic information for the three participating BCTB States. State data bases for child care services and relevant national statistical information do not produce relevant planning information. The information needed includes child care demand by age of child, family income for families with children under age three who need child care, and the supply of regulated child care spaces by age.

Florida

Sources of revenue

Florida is a state without an income tax. Its state funding comes primarily from sales taxes and lottery funds.

Characteristics of the service system

Florida has a tradition of highly decentralized licensing. Licensing is seen as a local function, either performed by local social services staff or county government staff. Statewide licensing of child care centers was initiated in 1974, after years of effort. Statewide licensing of family child care homes does not exist.

Table 1: Baseline Demographic Characteristics of The Three States			
	Florida	Illinois	Utah
Population[1]	12m	11.6m	1.7m
Median income families with children	$30,000	$38,000	$35,000
Children under 18	2.9m	2.9m	628,000
% of child population living in poverty	20.9%	21.0%	11.5%
% of children without health coverage	26.8%	14.3%	12.8%
% children in single parent families	28.8%	27.2%	15.5%
% of all infants born to teen parents	9.6%	10.6%	4.7%
Children: 35 months and younger (0–3)[2]	509,129	510,109	101,444
Children: 71 months and younger (0–6)	1,109,004	1,018,444	204,906
% of children < 6 with both parents or only 1 in labor force	57.8%	54.2%	52.2%
# of women in labor force with youngest child < 6	443,639	411,075	76,115
% of women in labor force with youngest child < 6	63.2%	58.8%	57.0%
Immunization Rates:[3] at school entry by age 2 years[4]	49.3%	60.7%	35.8%

1 All data from the following source unless other wise noted: 1992 Kids Count Data Book: State profiles of Child Well-Being. Center for the Study of Social Policy, Washington, D.C. Most data used, 1990.

2 1990 Census of Population, General Population Characteristics, United States, 1990 CP-1-1, Washington, D.C., Department of Commerce, Bureau of the Census. Age of child completed years as of 4/1/90.

3 1991 data, Centers for Disease Control and Prevention, Division of Immunization. Data collected from annual state reports.

4 Children's records were reviewed at school entry to determine what the childs immunization status was at age 2.

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In contrast to this decentralization, other health and human services in the state had been consolidated into a super-agency, the Department of Health and Rehabilitative Services (HRS). Among a myriad of other functions, HRS oversaw all child care funded with public dollars. Quality in publicly supported child care, including publicly supported family child care, had long been addressed by funding requirements. Centers and homes wishing to receive federal and state child care subsidy funds had to be licensed and also meet certification requirements more stringent than licensing requirements.

New challenges and Florida's response

During the 1980s, Florida experienced severe impact from the drug and AIDS crises. A 1986 survey showed that as many as 5,000 Florida babies were born drug-exposed; by 1989, that number was estimated to be 10,000. In 1989, Florida ranked third nationally in the total number of AIDS cases reported. The state had the second highest number of reported pediatric AIDS cases (Select Committee on Children, Youth, and Families, 1990). This crisis added to the pressure on the child care system to provide more spaces for respite care and care needed by foster families who were employed.

Infant child care needs in the state had expanded dramatically for other reasons: the need for infant protection in substance-abusing families; immigration into the state from foreign countries and residents from other states seeking better economic opportunity during the 1980s; the teenage birthrate; and the overall need for both parents to work in order to stay out of poverty.

In 1989, the state had enacted the Florida Prevention, Early Assistance and Early Childhood Act, which mandated coordination between the Department of Education and the Department of Health and Rehabilitative Services around a continuum of services for high-risk pregnant women and for children birth to five at risk of or with special needs and their families.

By 1990, Florida also had several initiatives in place to respond to this stress on the child care system. These included: Project Independence (welfare reform); a twenty-hour training requirement for caregivers in licensed facilities; the expansion of the child care resource and referral network; hiring of family child care recruiters; and development of a child care facility/family day care home loan program (Kassack and Winstead, 1990).

Illinois

Sources of revenue

Illinois has an income tax which was capped at 2.75%. User fees and lottery funds supplemented Illinois' revenue. Limited tax funds coupled with increasing competition for limited resources made it very difficult to increase funding for child care.

Characteristics of the service system

Child care was primarily administered through two state agencies: the Department of Children and Family Services (DCFS) and the Department of Public Aid (DPA). DCFS administered SSBG child care funds and DPA a range of child care programs funded through Title IV-A and the Family Support

Act. DCFS operated all of these child care programs through its regional offices. Coordination between the two agencies continues to remain a major goal of state administrators and other child care leaders.

According to an Illinois administrator, "Illinois faced the same problems as the child care field across the country. Low wages and high caregiver/teacher turnover indicated that the quality of care was poor at best."

In Chicago, the statewide problem of the supply of licensed infant child care was intensified by arcane fire and safety regulations that were developed from an old medical model of hospital newborn nursery practices. These regulations contributed to the fact that there were only three licensed centers providing infant care in Chicago.

New challenges and Illinois' response

By 1990, Illinois had held a Child Care Summit which made six detailed recommendations for immediate state action to help improve quality and make child care for low-income families more accessible, stable and cost efficient.

To coordinate child care on the local community level, Illinois developed a system of 16 child care resource and referral (CCR&R) agencies. The agencies are involved in a wide range of activities such as provider training, technical assistance, recruitment, and client referral/consumer education. To coordinate early intervention services across the state, Illinois developed a Statewide Early Intervention Council in accordance with P.L. 99-457. Additionally, the DCFS and the DPA began building a close relationship that set the stage for coordinated rates and seamless services for clients.

Utah

Sources of Revenue

Funding for child care in Utah comes from state general funds, federal programs, user fees, foundation support and other sources.

Characteristics of the service system

Utah had a strong EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program known as CHEC (Child Health Evaluation and Care) that served as a child health care financing system.

Utah also had a nationally recognized statewide comprehensive health and outreach program for pregnant women, infants and children called the Baby Your Baby Program. This program was administered by the state's maternal and child health agency. By 1990, this program had six components, including a statewide coordinated care management system that integrates services for children in EPSDT, Children with Special Health Care Needs and Early Intervention (P.L. 99-457) programs (van Dyck and Delavan, 1991).

In contrast to infant and child health care, infant child care services were in the early stages of development. In 1989, there were 244 licensed child care centers serving about 18,000 children; of these, 1,381 were infants, dispersed throughout the 130 centers licensed to care for infants. Salaries were low in child care centers ($4.08 per hour for teachers in 1988 and $3.65 for teacher aides) and turnover was high (46% in 1988) (Olsen, 1989).

Of the 12,000 children served by the 1,500 licensed family child care homes, it was not known how many were infants and toddlers. Many employed Utah parents turned to relatives to care for their infants and toddlers. Family child care, however, seemed to be the out-of-home child care arrangement preferred by Utah parents for infant/toddler care.

The state had only one comprehensive child care resource and referral agency, while others throughout the state were in the planning phase.

Furthermore, the state's investment of public dollars in child care and early education was small. In 1988, there were only slightly more than 7,500 Title XX slots, in a state with 184,000 children under the age of five and 81,000 children living in poverty (Children's Defense Fund, 1990). Utah spent $10 million in public funds on child care (52% of that from federal funds) in Fiscal Year 1990.

New challenges and Utah's response to these challenges

Utah seemed poised to develop more organized child care services in its own way. In 1989, the governor established a Commission on Child Care, which called for establishment of an Office of Child Care and Development within the governor's office and with a budget of $500,000. The state legislature created this office, appropriated $100,000 for it and then placed it in the Department of Community and Economic Development, the state agency that encouraged business investment. The state administrator of FSA child care and other child care for low-income families wanted to be able to work with this office to plan expansion of resource and referral services and training opportunities.

To BCTB, Utah offered a unique opportunity to help a state plan for quality protection and improvement in infant child care at the earliest stage of development. It also offered a unique opportunity to encourage linkage between a strong infant health initiative and infant child care services, especially family child care services.

Once the states were selected, the other elements of the BCTB project, letters of agreement, a multidisciplinary team, collaborative process and policy-responsive technical assistance content became the primary features of the project.

4. Use of goal-directed letters of agreement.

With strong encouragement from our first private foundation project officer, we decided to use formal letters of agreement as the framework for our state-specific technical assistance (Shelby Miller, personal communication). The development of these letters enhanced the goal-orientation of the project.

The letters often originated in a consensus development process within each state occasionally in a consensus development process between the state and BCTB. Thus, the process itself offered many opportunities to identify and sort through options and to make decisions about goals.

Initially, we anticipated that one letter of agreement would suffice for the life of the project. However, as the financial support to the project grew, we offered each state the opportunity to revise the agreements.

The process of revising the letters of agreement provided an opportunity to rework the objectives and strategies chosen to realize the project's goals—and in the case of one state, to adapt the goals. Since significant fiscal and political changes occurred at both federal and state levels during the life of the project, this flexibility was important.

In the first letters of agreement each state:

- committed itself to the goal of quality improvement in infant child care and to the training and health-access related subgoals;
- specified the objectives that would be used to realize these goals (e.g., develop a state training plan in order to increase opportunities for infant caregiver training);
- agreed to form an interagency BCTB team comprised of representatives from the governor's office and the administrators of child care, early intervention (Part H), maternal and child health, and the EPSDT program;
- agreed to send representatives to the BCTB national technical assistance forum; and
- agreed to develop two new initiatives related to preventive health and child care and infant/toddler caregiver training or to strengthen the emphasis of existing efforts.

ZERO TO THREE and the BCTB Project (staff and selected consultants) committed themselves to at least two technical assistance site visits per year, each lasting one-and-one-half to two days and at least 70 hours of additional written or telephone technical assistance each year to each state.

The following excerpts from the letters of agreement outline the objectives each of the three states chose to address with the BCTB national team.

The Florida initiatives and areas of BCTB project assistance are outlined in its second letter of agreement:

- assistance in planning the details to integrate preventive health services with child care programs by:
  - — reviewing health and safety standards and making recommendations about possible changes, and
  - — planning a presentation/discussion of instrument based monitoring of child care;

- development of a joint Department of Health and Rehabilitative Services and Department of Education statewide training plan for providers of early childhood services for infants and toddlers; and

- time permitting, assistance in selecting three demonstration sites "that will develop and implement plans to increase the participation rates of Medicaid-eligible infants and toddlers in the full range of health services currently mandated in the federal Medicaid program."

Florida's third letter of agreement continued these efforts, focusing BCTB efforts on:

- assistance with the development of a common assessment process of quality early childhood services (Human Services and Education) by developing common health and safety standards and monitoring instruments;

- continuation of work on the joint training plan; and

- time and funding permitting, further development of a plan to place health coordinators at key points in the state who will advise early childhood service providers about health and safety requirements in the common standards, the availability of community health resources and recommendations on practices for assuring that health and safety requirements are met.

Illinois initiatives and BCTB technical assistance efforts are outlined in their second letter of agreement and include:

- identification of financing options under Medicaid and Part H that would allow for the provision of coordinated services for eligible infants and toddlers participating in child care programs, including environmentally at-risk infants and toddlers;

- assistance with the revision of city standards for infant care in Chicago (including the provision of information related to state and municipal building, zoning and health codes and a review of the draft standards);

- research of the literature for studies that substantiate flexible but quality approaches to standards for infant child care;

- assistance in the development of a plan to recruit, train and retrain child care providers to serve substance-exposed infants (including a review of models used in other states);

- assistance with the development of a plan to expand infant child care in Illinois and review models from other states;

- further assistance to Chicago on its standards; and

- identification of other available federal funding streams. (The national BCTB team will produce a paper specific to Illinois that will describe and analyze funding available for infant toddler early childhood services and for the training of infant/toddler caregivers.)

Illinois' third letter of agreement specified BCTB assistance in the following ways:

- assistance with the improvement of licensing and registration requirements, procedures and training of licensing personnel;

- assistance with development of a preservice and inservice training program for licensing personnel in the areas of services and resources that would be helpful to child care providers (improvements in caregiving practices and caregiving environments). The BCTB national team will identify, review and recommend training materials present in other state licensor training models, and assess the feasibility of implementing an instrument-based monitoring system, etc.;

- completion of a detailed comparison of Illinois' child care requirements and the APHA/ AAP standards that can used in the regulatory review process and related to the implementation of the Child Care and Development Block Grant.

- assistance with planning related to the integration of children's health programs with child care, Head Start, and state school-based programs, coordinating health and safety outreach and consumer information, and collaborating on early identification, tracking and follow-up services; and

- as time permits, BCTB and Illinois might explore interagency collaboration to increase the effectiveness and efficiency of data collection and the pooling of data across service systems.

Utah's initiatives and BCTB's efforts to provide technical assistance are covered in Utah's second letter of agreement and include:

- development of a system to assure that all infants and toddlers in attendance in licensed child care centers and family day care homes in Utah receive preventive health care services through the state's Baby Your Baby Program, coordination of this program with the revised EPSDT program and the Early Intervention program;

- assistance in carrying out a needs assessment to identify the number of children in the existing child care system who may still lack resources or access to well child care;

- assistance in the review of existing child care health policies and health related forms;

- assistance in the review of computerized linking capabilities between the Department of Human Services' day care attendance and the Department of Health's preventive health care files;

- facilitation of the creation of a state plan for the training of caregivers of infants and toddlers in the state of Utah that will incorporate preventive health care issues (including issues related to early intervention for infants and toddlers with special needs) and developmentally appropriate practice including:

— assistance with a survey of existing training opportunities in both rural and urban areas of the state, designed to identify gaps and duplications;

— assistance in the development of a resource directory of available training programs for both rural and urban populations;

- collaboration to produce a plan for increasing training opportunities, improving existing training so that training experiences will better "fit" the knowledge base, skill level, time, financial constraints and other demands on caregivers; and

- linkage of training opportunities to state-led initiatives seeking a higher reimbursement rate for caregivers.

5. Development and use of a multidisciplinary technical assistance team.

Consistent with our focus on the whole baby and on family-centered and comprehensive services, we developed a project team that included the following BCTB staff or consultants:

- early childhood educators with experience in federal and/or state policy development and/or implementation (Griffin, Pizzo, Morgan, Argenta, Fiene);

- infant and child development specialists with experience in federal and state early intervention-related policy development (Szanton, Argenta);

- infant and child development specialists with experience in actual program practice related to infant/toddler child care and early intervention services (Griffin, Argenta);

- a pediatrician with experience in state policy development and the development/ evaluation of health and safety regulation, training, consultation and technical assistance for child care (Aronson); and

- social science researchers with experience in evaluation (Fiene, Griffin).

We also worked with a public interest attorney experienced in health, disability and poverty law, and public policy, including health care financing (Chavkin) to develop technical assistance materials and/or advice to state administrators.

In addition, we developed a project advisory group that included experts in health, early care and education, training, and public policy development and implementation (see Appendix A).

We were fortunate to have regular advice and counsel from five members of the **ZERO TO THREE** board, who collectively represent extensive knowledge and experience in pediatric medicine, early care and education, infant and child development, social work and in the family resource movement (Lally, Provence, Straus, Weissbourd and Zigler).

6. Emphasis on an evolutional, collaborative and cross-agency process.

Although the national BCTB project team did not plan a technical assistance process in advance, we did stipulate that the BCTB technical assistance process should include the following three elements:

- collaborative planning;
- technical assistance site visits; and
- telephone and written technical assistance.

Collaborative planning was encouraged: (1) within the national BCTB team; (2) between the national BCTB team and the state administrators; and (3) among the diverse state administrators on each state BCTB team. In 1991, when new federal child care legislation was being implemented, we also encouraged cross-state collaborative implementation planning, involving the child care administrators from the three states in one face-to-face and several telephone meetings. This approach was also used effectively in the national technical assistance forum "Finding and Funding Quality Child Care and Head Start Services for Infants and Toddlers," held in June of 1991.

The letters of agreement provided a useful focal point for collaborative planning—particularly since they had to be signed by the governor or his designated representative. Although we (and some of our funders) felt strongly that involvement of the governor's representative was an essential element in encouraging cross-agency collaboration, some of the state administrators expressed reservations about the role of the governors' office and the priority given to it.

Technical assistance site visits were significant events that required weeks of planning and (whenever feasible) weeks of follow-up activity as well. We initially asked that the entire cross-agency team be available for all or part of the one-and-one-half to two-day site visits. This proved to be quite difficult, given the often unpredictable and always busy schedules of the state administrators. Over the course of the project, we tried different formats.

Telephone and written technical assistance initially involved the preparation of memoranda responding to specific requests, and of overhead projector transparencies for briefings. Over time it evolved to include the transmission of federal Requests for Proposals (RFP's) relevant to child care quality improvement and the production of both state-specific technical assistance papers and nationally relevant policy papers. Telephone technical assistance included one-on-one, small group and large group telephone meetings.

We did not plan other elements of the technical assistance process, but let them evolve over time, as the needs indicated. After the first few months, collaborative process evaluation, the ongoing evaluation of how well the project was meeting the state's needs, was incorporated into the design. The national BCTB team members met together at least once a month and BCTB project staff and the participating state administrators reviewed the project each time a letter of agreement was revised.

Policy-Responsive Technical Assistance Menu

Our decision to allow the content of our technical assistance to evolve as the needs were indicated resulted in a technical assistance menu that included the following elements:

- training;
- integration of the health and child care services systems;
- integration of the early intervention and child care services systems;
- the revision of licensing requirements;
- the implementation of licensing requirements;
- the implementation of new federal child care regulations; and
- the financing of a whole-baby, family-centered approach to early childhood services.

At times the open-ended approach to our technical assistance proved troublesome to individuals who wanted a concise description of either our process or the content areas in which we were prepared to offer technical assistance. About midway through the project, therefore, we did produce brief descriptions (see Appendix B).

CHAPTER IV:

PROJECT OPERATIONS

BCTB Inputs to Policy Improvements: Dissemination of Information

Information was provided about: (1) research findings and expert opinion useful to inform or support policy decisions; (2) policy improvement strategies in use or in development by other states; (3) new federal policy developments; and (4) sources of funds that states could use to support policy and/or service improvements (see Appendix B for summary).

1. **Research findings and expert opinion useful to inform or support policy decisions.**

   BCTB staff and consultants provided information about the most recent research results and attendant recommendations related to:

   (a) the prevention of damage to an infant's emotional development and the promotion of good development (Florida, Illinois);

   (b) the prevention and control of infectious disease in infant child care (Florida, Chicago/ Illinois);

   (c) the prevention and control of childhood injury, particularly through fire safety, prevention and effective building codes (Illinois);

   (d) the elements of effective training for infant care practitioners, particularly those elements recommended by **ZERO TO THREE**/NCCIP's TASK project (Illinois, Florida, Utah);

   (e) the key health and safety requirements for infant child care (Florida and Illinois);

   (f) the monitoring of child care, particularly those elements used in instrument-based monitoring (Florida, Illinois, Utah); and

   (g) the potential uses of child care resource and referral services (Florida, Illinois, Utah).

2. **Policy improvement strategies in use or in development by other states.**

   BCTB staff and consultants provided information about other states' policy improvement strategies related to:

   (a) developing statewide training plans that emphasize career development as well as the acquisition of knowledge and skills, particularly those fostered by the Wheelock College Center on Career Development in Early Care and Education (Florida, Illinois, Utah);

   (b) models of support to family child care providers through provider associations and networks centered around resource and referral agencies and training, particularly those developed by Save the Children in Atlanta, Windflower in Colorado, Mervyn's Department Store, and the National Council of Jewish Women (Florida, Utah);

(c) models of regulatory approaches to family child care, particularly those being developed by the state of Washington (Florida, Illinois & Utah);

(d) developing statewide resource and referral systems, particularly those in use in California and New Jersey (Illinois, Utah);

(e) fostering collaboration between child care and child health, particularly those programs in use in Pennsylvania through the Early Childhood Education Linkage System (ECELS) project (Florida, Illinois, Utah) and in development in Utah as a component of the Baby Your Baby Project (Florida, Illinois);

(f) fostering collaboration between child care and early intervention services, particularly those in use and in development in Florida (Illinois);

(g) developing voucher-based financing of child care as a companion to (rather than replacement for) financing of child care through contracts (Illinois, Utah and others);

(h) implementing the Family Support Act, the Child Care and Development Block Grant and the Title IV-A At-Risk Child Care funds, particularly those strategies being tracked by the Foundation for Child Development and the Children's Defense Fund (Florida, Illinois, Utah);

(i) implementing the federal regulations related to child care developed by each of the BCTB states (Florida, Illinois, Utah); and

(j) developing approaches to evaluation of child care that integrates program evaluation with monitoring for regulatory compliance and that results in concrete data about child care quality throughout the state, particularly the approach in use in Pennsylvania (Florida, Illinois, Utah).

3. New federal policy developments.

BCTB staff and consultants obtained and shared information about new federal laws and regulations as much as possible while these policies were still in development, in order to alert state policymakers to new opportunities and requirements that related to state policy. In order to exchange ideas about implementation strategies, information was also provided soon after the following federal policies were enacted:

(a) the 1989 Omnibus Budget Reconciliation Act (OBRA) Medicaid expansions, both in terms of eligible populations and the scope and comprehensiveness of services to which eligible children and pregnant and postpartum women are now entitled (Florida, Illinois);

(b) the 1990 reauthorization of the Head Start Act, as well as the enactment of the Child Care and Development Block Grant and of Title IV-A At-Risk Child Care funds (Florida, Illinois, Utah);

(c) the 1991 promulgation of the federal interim final rule on the Child Care and Development Block Grant as well as the proposed Title IV-A At-Risk Child Care regulations, including those provisions proposed for retroactive application to the Family Support Act (Florida, Illinois, Utah);

(d) the 1991 reauthorization of the Individuals with Disabilities Education Act (Illinois); and

(e) the 1992 implementation of the Americans with Disabilities Act (Illinois).

4. Sources of funds that states could use to support policy improvements.

When providing information about the new federal policy developments, BCTB staff and consultants alerted state policymakers to sources of federal funds authorized by these new laws. In addition, BCTB staff and consultants provided information about higher quality infant child care (e.g. whole baby, family-centered infant child care) and described, in published policy papers, how to piece together various sources of federal funds to enhance the quality of infant/ toddler child care. The written papers and group presentations, are described below:

(a) "Whole Babies, Parents and Pieces of Funds" was researched and written in 1989-90. It examined ways that states could piece together the new Medicaid and Part H funds with child care, social service and nutrition funds to finance infant child care that would provide health, nutrition and family support services to both children and parents (Florida, Illinois, Utah).

(b) "Toward a Seamless System," was a briefing via overhead transparencies researched and written in 1991, built on the work done in "Whole Babies" but with added information about the child care funds authorized in 1990, the new Head Start emphasis on infants and toddlers and the Comprehensive Child Development Programs (Florida, Illinois and Utah, at the Better Care for the Babies Technical Assistance Forum in June 1991).

(c) "Medicaid and Child Care," was researched and written in 1991. It continued to develop the possibilities for piecing together Medicaid, Part H and child care by describing five aspects of child care's mission related to health, early intervention and family support that can be financed, for Medicaid-eligible children, with Medicaid funds. It also emphasized that states could use all or part of a state's own appropriation for early childhood services as the state match for Medicaid (Florida, Illinois, Utah).

(d) "Seven Sources of Federal Funds," an analysis of existing federal laws, appropriation levels, recommended levels, oversight and mandates as they applied to Illinois (Winter, 1991).

In addition, BCTB project staff periodically alerted the state administrator/liaisons to research and demonstration grant opportunities, such as those made available by the Administration for

Children, Youth and Families to promote collaboration between state governments and Head Start. Conversely, opportunities for state governments to work collaboratively with influential private sector initiatives—such as the Kiwanis organization's Priority One campaign for children and families—were also brought to the attention of the state policymakers with whom we worked.

BCTB Inputs to Policy Improvements: Opportunities for Networking

In 1991, the BCTB technical assistance forum brought together state child care administrators from 46 states with leadership in the infant child care, child health and Head Start fields. See "Finding and Funding Quality Child Care and Head Start Services for Infants and Toddlers," (Argenta, Pizzo, Griffin, 1992) for a report of this technical assistance conference as well as "Promoting Change in State Policy Decisionmaking on Quality Infant/Toddler Child Care and Head Start Services," (Griffin and Fiene, 1992) for the results of an evaluation of the forum.

The forum gave state administrators—including many of the BCTB team members from each of the three states—an opportunity to meet and compare notes regarding state infant child care quality improvement and supply-building strategies. This opportunity for information exchange and informal collaborative planning among state administrators was heightened when the federal government coincidentally decided to release the interim final CCDBG and the proposed Title IV-A At-Risk regulations about the same time the technical assistance forum was held. BCTB project staff invited Mark Ragan, from the federal Department of Health & Human Services, Administration for Children and Families (the agency with oversight of all federally funded child care) to discuss the regulations.

BCTB team members valued the opportunity to learn how other states planned to use the new federal monies and to cope with interim and proposed regulations that seemed to impede state policy planning that emphasized quality improvement. Face-to-face meetings among the BCTB team members from each of the three states were also helpful as each of the state administrators could offer strategies that proved effective in their state and gain new ideas, or get the affirmation of others—a vital source of encouragement state administrators receive too infrequently.

After the forum, several state BCTB team members requested additional opportunities for networking with other state administrators, particularly to share ideas related to implementation of CCDBG and Title IV-A At-Risk funds. Since no funding was available for a meeting, we set up a series of telephone conference calls with state administrators and other issue-specific experts to discuss mutual concerns.

State Policy and Service Improvements

Our knowledge about the policy improvements described below is derived from: (1) policy-related documents produced by government agencies and nongovernmental leaders within the three states; (2) interviews with state administrators in these states; and (3) field notes, taken during site visits to the states as well as during telephone meetings occurring in the period between site visits.

The authors do not suggest that these policy improvements are even mostly attributable to the technical assistance of the Better Care for the Babies Project. The purpose of this part of this chapter is primarily to inform the reader of policy improvements that did occur in these three states, undoubtedly as a result of multiple contributing factors. Some of these policy improvements were entirely beyond the control of the BCTB technical assistance effort; some were only marginally influenced by BCTB; others may have been directly or indirectly helped by BCTB. BCTB's contributions to or input into these policy improvements are discussed and analyzed in a separate section at the end of this chapter, based on telephone interviews with the key state administrators with whom we worked.

During the years 1989–1992, all three states accomplished policy advances in most or all of these eight areas:

(1) protection of quality child care and improvement in policy planning for implementation of the Family Support Act, the Child Care and Development Block Grant and Title IV-A At-Risk Child Care programs;

(2) increased consolidation of child care oversight and coordination of disparate funding streams, with an emphasis on quality improvement in all child care, including child care funded under the Family Support Act;

(3) substantially increased support for training as an essential element in quality improvement;

(4) increased reimbursement for publicly funded child care, leading to at least some deeply needed wage improvement among subsidized child care providers;

(5) strengthened consumer education services, including materials and services designed to help parents choose good child care;

(6) stronger linkage between child care and early intervention services for infants and toddlers;

(7) improved health and safety requirements for infants and toddlers in child care; and

(8) improved linkage between child care and preventive health services.

BCTB's helpfulness was not experienced evenly in all three states for each of the policy improvements listed above. The nature of BCTB's contribution and the state administrators' perceptions about the relationship between BCTB inputs and the states' policy improvements will be discussed more fully later in this chapter.

Policy Planning

In 1989, most states were funding child care for the working poor principally through the Social Services Block Grant (Title XX). The FSA of 1988 had been enacted; final implementing regulations,

however, were not published until October, 1989, and states were not required to begin implementation of the JOBS employment and training component of FSA until October, 1990.

Prior to implementation of the FSA and enactment of the 1990 child care legislation, all three states had initiated policy planning for quality improvement.

Illinois held a Child Care Summit in 1989, convened by the governor's office and the directors of the Department of Child and Family Services and the Department of Public Aid. The Child Care Summit had substantial input from child care advocates and program administrators. The goal of the summit was to evaluate and improve ways in which Illinois developed, financed, delivered and monitored publicly subsidized child care. Six major recommendations addressed reducing bureaucratic complexity and inefficiency and increasing information to eligible families regarding availability of services and subsidies.

The summit also explored how the state could use its various child care resources to assure continuity of care for the family moving off welfare and into the work force. Finally, the summit identified ways to increase the availability of child care to subsidized families by, for example: improving reimbursements to child care providers; changing the market rate methodology; changing the policy regarding payment for days the child does not attend (100% reimbursement for 80% attendance); and developing a capital loan fund to support the opening of new child care services (State of Illinois, 1991).

Florida enacted the Prevention, Early Assistance and Childhood Development Act in 1989. This act established a State Coordinating Council for Early Childhood Services and mandated the Department of Health and Rehabilitative Services and the Department of Education to develop a joint strategic plan that would foster a "seamless continuum of locally delivered prevention and early intervention services." This plan was published in 1991.

Utah established a Governor's Commission on Child Care in 1989. The commission recommended the establishment of a state Office of Child Care in the Governors office charged with "long range planning, coordination and implementation of child care services in Utah (Walher, 1989)." This office was established in 1990 in the Department of Community and Economic Development.

All three states emphasized quality improvement in their planning for the implementation of the Family Support Act, the Child Care and Development Block Grant and the Title IV-A At-Risk Child Care funds. This was a substantial accomplishment, because as noted previously, interim and proposed federal regulations presented the states with numerous obstacles to quality improvement.

Florida took a holistic view of subsidized child care and decided to use CCDBG funds to raise reimbursement rates for all subsidized providers, regardless of the source of subsidy. In so doing, Florida decided to emphasize health and safety protections for all children touched by subsidized funds, including children in unregulated (exempt from regulation by state law) care funded under the Family Support Act or Title IV-A At-Risk Child Care. Florida's child care leadership, along with a number of other state child care administrators, reasoned that once they had mingled CCDBG funds with Title IV-

A funds (which they did by using CCDBG funds to raise rates for Title IV-A and other subsidized care), they were free to require child care providers serving eligible children to at least meet the health and safety protections required of all CCDBG funded care. The Interim Final Rule for CCDBG took precedence over the Notice of Proposed Rulemaking for Title IV-A At-Risk.

Consequently, all nonrelative Title IV-A-funded child care providers in Florida are required to self-certify that they meet the health and safety requirements expected of all CCDBG funded non-relative child care. The final CCDBG rule and the Title IV-A At-Risk Child Care rule, validated Florida's position. These final regulations: (1) gave states the right to use funding as well as licensing requirements to establish some level of health and safety standards; and (2) gave states the option to deny payment to child care providers who do not meet health and safety standards required under other federal funding sources.

While Florida's child care advocates support self-certification as a positive step, they hope to be able to persuade the state legislature to support statewide licensure of family child care homes in the future (Muenchow, personal communication, 1992).

Despite a ban on "differentiated rates" (paying higher rates for higher quality) in the CCDBG Interim Final Rule, a number of states including two of the three BCTB states, were allowed to delay the differential rate decisions until the final rules were published (8/92) or until a certificate payment program was implemented (by 10/92).

Utah emphasized quality improvement in its CCDBG policy planning. Like Florida, the state specifically decided to "examine and implement a system to pay providers who deliver a higher level of quality of care at a higher rate" (State of Utah, Department of Human Resources, 1991). The Utah state administrators viewed "differentiated rates" as a means of rewarding quality by helping providers offset the costs associated with higher quality.

In 1989, the Governor's Commission on Child Care in Utah had recommended that more highly trained providers be awarded higher reimbursement rates. As Utah planned their voucher system under CCDBG, this principle of higher rates for higher quality was a central one. The state planned to establish criteria—including training—for providers (including license-exempt providers) who wish to qualify for these higher rates. However, Utah withdrew the language in order to get the CCDBG plan approved.

Illinois also took a holistic view of subsidized child care and used CCDBG funds to make the fee scale more equitable for low-income families. This is just one example of Illinois' commitment to coordinating and linking funding streams so that all families receiving subsides are treated equally. While Illinois has not commingled At-Risk and CCDBG funds, reimbursement rates, health and safety requirements, and service coordination are the same for all subsidized child care.

To ensure that Illinois clients moving off of Transitional Child Care (TCC) continue to receive care after their 12-month entitlement, Illinois is automatically moving them onto the new Title IV-A At-Risk funds.

All three participating BCTB states have increased the efficiency of their delivery systems by simplifying the intake and billing systems, expanding the resource and referral system, and developing a consumer education campaign. They all set aside CCDBG funds for the ongoing funding of statewide systems of child care resource and referral services.

Using the federal Child Care Licensing and Improvement Grant (an important source of funds tacked on to Title IV-A of the Family Support Act for three years and now gone), Illinois has taken on a variety of innovative quality improvement projects including: (1) planning provider workshops and training; (2) serving children with special needs and developing integrated settings; (3) building a workforce for the future; (4) providing comprehensive on-the-job training demonstrations; and (5) sponsoring research to obtain child care information on very low-income families.

In the area of health care for very young children, Illinois will be implementing a new system of case management for Medicaid eligible mothers and their young children in Chicago, beginning in 1992. This program, Healthy Moms/Healthy Kids, is an effort to provide both preventive care and medical treatment in a systematic way.

Consolidation of Child Care Oversight

As noted earlier, between 1989 and 1992, states were given responsibility for administering three new wholly or partially federally funded child care streams designed to serve different populations of children and families: the Family Support Act (FSA), the Child Care and Development Block Grant (CCDBG) and Title IV-A At-Risk Child Care.

Experienced observers knew that if the states failed to organize the administration of these separate funds in a unified way, the function of oversight would be scattered among a variety of agencies, including some whose mission was much more concerned with job placements for parents than with quality child care for children. A major challenge for the states was the design of a sensible and equitable way of planning for and administering these new funds at the same time as protecting whatever strengths already existed in state child care services.

Children participating in FSA-funded child care are often the poorest of the poor—at higher risk for multiple health, mental health and developmental problems. One major risk associated with the passage of the Family Support Act (with few provisions for quality improvement) was that these children, the children of AFDC parents making the transition from welfare to work, would not benefit from the quality improvement provisions in the Child Care and Development Block Grant.

However, the consolidation or coordination of child care oversight in Utah, Florida and Illinois permitted and enhanced policy planning that benefitted all children in child care in these states—including children in care funded under the Family Support Act.

Utah, for example, emphasized policy planning for training and the development of a statewide resource and referral system in ways that would benefit all children and families. The state consolidated the administration of FSA, Title IV-A At-Risk, CCDBG and state-funded child care, in the Office of Family Support. This did not include oversight of licensing, which was lodged in a separate Office of Licensing. The consolidation allowed Utah to encourage participation in training by providers generally, regardless of the source of payment to the provider. In January, 1992, a portion of CCDBG funding was transferred from the Office of Family Support to the recently established Office of Child Care, where the appointed statewide Training Coordinator and the Resource and Referral Coordinator are located. This was done to stabilize the newly formed office and to promote further collaboration on child care issues.

In Florida, consolidation included FSA child care, CCDBG, IV-A At-Risk Child Care, Part H of the Individuals with Disabilities Education Act and other federal or state programs on funding sources together with licensing, training, and resource and referral. One office, the Children, Youth and Families (CYF) Program Office within the Department of Health and Rehabilitative Services, administered all these services. In addition, in Florida, the legislatively mandated State Coordinating Council facilitated joint planning between the CYF office and related care and education services administered by the Department of Education.

This degree of consolidation and coordination was particularly useful to the planning of initiatives related to low-income and/or special needs infants and toddlers. Florida's implementation of federal and state early care and education programs affecting infants and toddlers and their families had been split between the CYF Program Office in the Department of Health and Rehabilitative Services and several units within the Department of Education. Florida's implementation of FSA, including the FSA-related provisions affecting teenage parents and their infants and toddlers, was supervised by the CYF Program Office. However, the Department of Education administered both teen parent programs in school districts throughout the state and the Part H program of early intervention services for infants and toddlers with (or at risk of) developmental delay. The State Coordinating Council formed a bridge between the Department of Health and Rehabilitative Services and the Department of Education and thus was able to facilitate more coordination in services for infants and toddlers at risk environmentally, and infants and toddlers with established disabilities and their families.

In Illinois, early childhood education and care is provided through more than 10 different funding streams administered by three state agencies: the Department of Children and Family Services (DCFS); the Department of Public Aid (DPA); and the State Board of Education (SBE). To ensure that coordination continues to occur, interagency agreements around the administration and operation of state child care resources were signed by DPA and DCFS. Through the interagency agreement, DCFS provides intake and billing for Transitional Child Care (TCC) and At-Risk clients.

To further strengthen the management of the child care system, Illinois is in the process of developing a computerized child care payment and tracking system for all subsidized programs. In the interim, administrators from the two departments worked to develop a single sliding fee scale, universal eligibility forms, identical requirements and definitions regarding legal care, and identical self-certification forms for license exempt programs. These simplified forms and procedures are making it much easier for families to receive the child care services they need. These simplifications ensure that families do not "fall through the cracks" since administrators will be able to change the funding source as necessary while maintaining continuity of care. For example, if a family completes their 12-month

entitlement to TCC, they will be automatically transferred onto the IV-A At-Risk or other funding sources without gaps in service due to reapplication.

Policy Support for Training

All three states made policy improvements in the area of training. In 1991, Florida expanded its training requirements for all caregivers in licensed facilities, from a 20-hour to a 30-hour introductory training requirement. The state initiated five separate 10-hour training modules one of which is specifically for caregivers of infants and toddlers.

The 1991, Florida legislature also required that by 1995 every group of 20 children in every licensed facility within the state must have at least one credentialed teacher with a Child Development Associate (CDA) certificate or equivalent. Rather than implementing this requirement in isolation from other policy improvements planned for the state's child care system, Florida began to plan a career ladder that would: (1) set out competency-based objectives for the training; and (2) integrate the new 30-hour training requirement and the requirement for a CDA or equivalent as the beginning steps on a progression that could lead toward a college and/or graduate degree. Florida set aside $473,000 in CCDBG funds to facilitate CDA training.

To facilitate career development, Florida established a state training coordinator position. This coordinator fostered collaboration among Florida's central agencies (local structures that administer public subsidies for child care and currently coordinate the 30 hour training), community colleges, universities, vocational-technical schools and community education programs; and developed a comprehensive training program that includes a career ladder.

Utah administrators made the building of a statewide child care training plan an important state priority. The first step in their plan was to assess the training needs and resources in the state. After surveying the state, they compiled two directories of training, which are to be updated at regular intervals. The statewide directories of both resources and opportunities were made available to all providers and local libraries in the state in 1991 and 1992. They also sent questionnaires to all child care centers and known family child care homes receiving state funds to ascertain the level and type (e.g., content area) of training and formal education of the state's child care workforce.

In addition, Utah emphasized the development of statewide training in its Child Care and Development Block Grant Plan and hired a statewide training coordinator who was expected to convene a task force to examine the training needs of child care providers and design a career track for child care providers.

Illinois set aside $728,000 of CCDBG funds for training, initiated a policy whereby providers could apply for funds to obtain training of their own choice for their staff, and gave priority in state-designed training to training in the care of children with special needs. Using the Federal Child Care Licensing and Improvement Grant to educate providers and professionals about the Americans with Disabilities Act (ADA), the state sponsored an informational training meeting in March, 1992, attended by more than 150 child care providers.

Reimbursement Rate Increases

All three states achieved better reimbursement rates for publicly supported child care. In so doing, Florida, Utah and Illinois provided a better statewide economic base for more stable, higher quality child care, particularly for the children of both the non-AFDC working poor and of AFDC parents making the transition off of welfare under the Family Support Act. In response to the recommendations of the state's 1989 Child Care Summit, Illinois revised both its rate-setting methodology and the actual rates just prior to enactment of the 1990 federal child care legislation. In 1991, Illinois twice raised rates for all publicly funded child care. Special emphasis was given to using federal funds to improve the rate for infant care: from $18.69 per day to $29.05 per day in centers and from $11.41 per day to $16.46 per day in homes. This represents a 55% increase in center-based rates and a 44% increase in family child care rates for infant care. In a state where the availability of infant care is so low, this was a major decision.

Faced with the need to improve both supply and quality of infant child care, Illinois recognized that providers need to be reinforced in their desire to do right by the child. Higher reimbursement rates are one example of one type of reinforcement. The state can also use higher reimbursement rates to attract additional providers capable of offering high quality infant child care. This position was strongly supported by Illinois' child care advocacy community. Across all types of care, (including child care purchased by families using the AFDC income disregard) Illinois was able to raise reimbursement rates so that all publicly funded providers were reimbursed at the 75th percentile.

Florida also used CCDBG funds to bring subsidized rates up to the 75th percentile statewide across all categories of care. They pointed to the federal policy emphasis on parent choice as a rationale for increasing the rates of all subsidized care with CCDBG funds, including care funded under the Family Support Act.

In Florida, this policy position was strongly supported by the provider community, which argued that the $21 million in CCDBG funds reserved for direct services (of the total $33 million in CCDBG funds for Florida) would be best used to raise reimbursement rates for providers across the state, rather than to simply expand the number of insufficiently reimbursed slots available. Without a rise in reimbursement rates, part of which could then be passed on to child caregivers in the form of wage increase, expansion of slots would be meaningless. Fewer and fewer child care providers could afford to stay in operation (Harris, personal communication, 1991).

Florida infant care rates were increased in each of the state's 11 service districts. In Fiscal Year 1991–92, the rates statewide ranged from slightly more than $12 per day to $17 per day in both centers and homes. In addition, Florida planned to implement these rate increases in ways that encouraged salary structures for CDA-trained workers enabling programs to pay competitive salaries.

Utah also decided to raise reimbursement rates for providers across all categories by 15 percent. Of the $5 million that was its CCDBG reserve for direct services, Utah decided to use $2.9 million to increase reimbursement rates. This increase occurred in two ways: (1) an across-the-board 15% increase for all subsidized providers, partly to reduce provider refusal to care for subsidized children; and (2) a decision to pay for up to 5 days of child absences (absences are typically paid for in the private sector). This latter decision particularly improves reimbursement for infant care, since infants are typically absent more often than older children. Utah also decided to use a small portion of these funds to study and set different rates for different populations of children, including infants and toddlers.

It is hoped that these higher reimbursement rates will translate into improvements in the abysmally low salaries of child care providers. Research shows that higher wages (for example, $6/hour rather than $4/hour) are associated with less caregiver turnover in child care (Whitebook, et al., 1989). For infants and toddlers in particular, who need stable caregivers in order to form the healthy attachments that are the foundation of human development, reductions in high caregiver turnover is an essential element of quality improvement in child care.

Strengthened Consumer Education

All three states improved parent/public education services, particularly through the development, enhancement and/or expansion of child care resource and referral services. With a three-way public/private partnership among DCFS, United Way of Chicago and DPA, Illinois developed a unique statewide child care resource and referral (CCR&R) project , designed to serve the needs of parents, providers, employers and communities. Illinois plans to link the statewide CCR & R's with child care funding sources via a statewide computer system, in order to facilitate "direct payments to providers on behalf of eligible parents (United Way of Chicago, 1989)."

The Illinois Department of Public Aid produced an innovative video entitled "All My Child Care," which informs families of available child care subsidies and child care resource and referral services. Consumer education brochures, posters and pamphlets were also developed.

Utah, which had one full-fledged CCR&R in the state in 1989, plans to use $160,000 of CCDBG funds to develop a statewide CCR&R system over a three year period, expanding services to eight or nine new regions (State of Utah, Department of Human Resources, 1991). Utah also planned to fund a central toll-free phone number for parents as well as public service announcements on quality child care issues. In addition, Utah established a Coordinator of Public Relations position and an R&R Coordinator position within the Office of Child Care.

Florida has committed $2.7 million of CCDBG funds to expand its statewide resource and referral network so that all localities can be served with sufficient parent counselors providing information in culturally sensitive approaches.

Linkage with Early Intervention Services

Florida focused on improving the capacity of child caregivers—including infant caregivers—to serve children with special needs. By 1990, the Florida Department of Education had developed the Model of Interdisciplinary Training for Children with Handicaps (MITCH), a series of training modules for caregivers of infants and toddlers with special needs. The 1991 Strategic Plan established as one of the state's eight program goals for prenatal and early childhood services, integration of children with disabilities into early childhood programs (State of Florida, Department of Health and Rehabilitative Services, 1991). The CCDBG plan included "enhanced rates" for child care for children with special needs and a plan to link child care resource and referral services with the Human Assistance Network Direction Service (HANDS), an electronic directory that facilitates community-based dissemination of information about services for children with disabilities and their families.

Utah recognized that implementation of the Americans with Disabilities Act would have ramifications for child care and decided to use some of its CCDBG funds to provide training and consultation services for caregivers serving children with special needs. Utah has also been providing early intervention services to infants and toddlers at their child care programs, particularly in the more rural areas where services are scarce.

In 1991, the Illinois Department of Public Aid commissioned a survey from the Institute of Applied Research to examine the child care needs and experiences of single parent families who were on or recently moved off of AFDC. The study documented that 15% of the families sampled had children with health problems or disabilities. Most of the parents surveyed expressed their concern about obtaining quality care that was nurturing and attentive to their children. Some preferred "informal" care arrangements with relatives and friends while others preferred centers or licensed day care homes. The study documented that parents earning low incomes want the same high quality care for their children as everyone else.

Improved Health and Safety Requirements and Monitoring

Both Florida and Utah revised their state licensing requirements and strengthened health and safety protections. In Illinois, all license exempt providers are required to self-certify that they meet health and safety requirements.

Florida amended the HRS child care standards in 1991 to significantly improve standards for immunization, specifying, for example, a requirement for vaccination against Hib disease (a potentially fatal vaccine-preventable disease) and requiring that the immunization office notify child care providers of any changes in medically recognized immunization practices. The amendments also specified in greater detail which medical conditions require exclusion of the child and, for the first time, provided more flexibility for providers electing to care for children who did not feel well enough to participate in regular activities (State of Florida, Department of Health and Rehabilitative Services, 1993).

In 1990–91, Utah revised its center-based requirements, making them more quality-oriented and comprehensive. Each director and all caregivers are now required to participate yearly in at least 20 hours of training, five of which are in child health care. Newly hired caregivers participate in an additional 20 hours of training—with a total of 10 hours (out of 40 hours) devoted to child health (Utah Department of Human Services, Office of Licensing, 1991).

In 1991, Utah revised its immunization requirements to include a requirement for the Hib vaccine, starting at two months of age. These new requirements became effective as of July, 1992. In addition, Utah's detailed Communicable Disease Control Guidelines were also developed.

Utah developed and implemented a plan to improve monitoring of provider compliance with licensing requirements. By February 1992, Utah had purchased two laptop computers for their four program monitors and were planning to develop a statistically validated indicator check list and to explore instrument-based monitoring with BCTB project staff and consultants in a future BCTB technical assistance site visit.

In Illinois, a very significant policy improvement made regarding health and safety requirements was the decision to propose to the City Council of Chicago that the city no longer require infant care centers to meet municipal licensing requirements in addition to the state's licensing requirements. As noted earlier, these municipal infant care center standards had been developed decades ago and contained health and safety requirements that were no longer necessary in this era of modern infection control and child safety measures. A sixty-member Task Force, established by the City of Chicago, had met since 1989 to examine these regulations, as well as municipal health, building and fire codes, and recommend alternatives.

If the City Council legislates the proposal to use only state requirements (rather than the combination of state and municipal requirements), it will probably reduce the multiyear delays in obtaining a license that have impeded the development of good quality infant child care in Chicago, while at the same time assuring infants and toddlers of the protections embedded in the state's licensing requirements.

Linkage with Preventive Health Services

All three states also initiated planning to link infant child care with preventive health care services. The following are examples of some of the initiatives.

The Baby Your Baby Program—Utah's statewide comprehensive health and outreach program for pregnant women, infants and children—is a model program. One component is the Well Child Care Program, which identifies infants and children who are at risk for health problems, developmental delay or hearing loss. Birth certificates, metabolic screening forms, confidential report forms and provider health status cards are screened, linked and matched within a computerized database. This linkage permits the creation of case records that "indicate risk factors for disabilities, identify health care providers and/or list diagnostic categories that are likely to require further review or follow-up" (van Dyck and Delavan, 1991). The database then drives follow-up activities—reminder letters, post cards and even personal phone calls. These activities encourage routine, periodic consultation with, and examination by, a health care provider.

The Office of Family Support in Utah, which ultimately oversees all child care within the state, also maintains a database that includes information about low-income children participating in child care. The national BCTB team concluded that there is likely to be substantial overlap between those in publicly supported child care and those who are at risk for health problems, developmental delay and hearing loss. Consequently, the Utah BCTB team has worked together to explore ways to compare and

share the data on children in subsidized child care with the data on at-risk children collected through the Baby Your Baby Program. When the two databases are integrated, they will allow state policymakers to examine patterns that indicate needs and intervention strategies that are likely to be effective.

Florida worked on a plan to fund health coordinators in Child Care Central Coordinating Agencies, using a combination of Medicaid and Title V funds to finance these positions. Unfortunately, implementation of this plan had to be deferred, due to the state's fiscal crisis. Florida's Strategic Plan also calls for expansion and improvement of screening and health services provided through early childhood education and care services.

Illinois initiated planning for health-related caregiver training and consumer education through the new statewide CCR&R services. The Chicago program Healthy Moms/Healthy Kids provides Medicaid-eligible families with preventive care and medical treatment.

Relationship of BCTB Inputs to State Policy Improvements

Is there any relationship between these BCTB informational inputs and opportunities for networking and the policy improvements we perceived in each of the three states between 1989 and 1992? To develop some understanding of this relationship, BCTB staff interviewed each of the state liaisons with whom we had worked (and in the case of Illinois, with the two state child care administrators and the City of Chicago child care administrator).

To foster the greatest possible candor, the interviews were conducted by a BCTB project staff person who had not been the technical assistance provider for the state and therefore did not have—and would be unlikely to have in the future—a technical assistance relationship with the state administrator being interviewed. The resulting interviews were characterized by a mixture of both positive and negative comments about the project and its approach, so we have assumed that there was at least some degree of candor in the responses.

One administrator felt that the project had not proved helpful to Chicago. While citing BCTB's technical assistance on family child care regulations and the site visits of Gwen Morgan and Susan Aronson as helpful, this administrator felt that technical assistance and the promotion of collaboration is not needed—"money is" (interview with M. Whelan, 1992). This opinion may reflect hard truth from an administrator. Since such overwhelming obstacles face urban children and families, much more money is needed if we are to provide quality child care to working poor families and those making the transition from welfare to work.

All of the state administrators interviewed from Florida and Illinois found the BCTB project helpful in making some progress on the infant child care quality improvement goals that BCTB Project and the state government teams agreed.

When asked to provide examples of "helpfulness," these state administrators cited examples of technical assistance provided on:

- training;
- regulations;

- initiatives underway or in development in other states as well as national efforts;
- new federal policies; and
- funding streams.

The state administrators also reported that the opportunities for networking with other state administrators provided through the technical assistance forum and through telephone meetings were helpful. Administrators also cited opportunities to exchange information and ideas personally with:

- nationally known consultants Gwen Morgan, M.S., and Susan Aronson, M.D., who often travelled with BCTB project staff; and
- leading state administrators who travelled with us to a particular state, including Peter van Dyck, M.D., who was the maternal and child health agency administrator from Utah, and Richard Fiene, Ph.D., child care administrator and administrator of the research office for children and youth in Pennsylvania.

One former state administrator from Florida, who had been the BCTB liaison when the project was first developed in Florida, felt strongly that BCTB technical assistance had provided "valuable information to support the state goal of improving staff-child ratios for infants and maintaining the placement of child care licensure in an agency for child and family services. In addition, the very involvement of BCTB staff in Florida created a climate for focusing state interest on infant child care (interview with S. Muenchow, 1992)."

Interestingly enough, when asked if the BCTB project had proved helpful in making "some progress toward goals that were principally your state's goals, but not necessarily the project's goals" these same administrators also responded "yes." They felt that BCTB had helped them improve the quality of care for children older than three—a goal outside the core mission of the project, which was focused on children under three. When asked to give examples, some administrators cited information on:

- health requirements—all subsidized areas (Florida);
- regulations, particularly family child care regulations (Illinois);
- voucher financing of child care (Illinois);
- the development of a career ladder within statewide training (Florida, Utah); and
- the development of a program for assuring greater availability of the Child Development Associate credential (Florida).

Not all the administrators perceived the BCTB project as helpful in realizing "agreed on goals." Utah stressed that while the BCTB project staff had been very helpful with technical assistance, shortage of time and funds in Utah had precluded as much participation as initially desired. "The issue is on Utah's side," this state administrator said, citing "difficulty in freeing staff" and state

administrators to work on the project (interview with T. Johnson, 1992). Constructive suggestions were offered in this interview—as in all the interviews—for improving the project's "fit" with states with similar time and money crunches.

Summary

Although no causal link can be appropriately drawn in a project that was not rigorously and impartially evaluated, it is safe to conclude that goal-directed technical assistance of the type that the BCTB project developed and carried out is one useful contributor to state policy development supportive of quality improvement in infant child care.

CHAPTER V:

LESSONS LEARNED AND RECOMMENDATIONS

After three years of providing goal-directed technical assistance to state policymakers, the Better Care for the Babies Project staff have concluded that this kind of technical assistance is a valuable contributor to good state policy development. It should become one of the quality improvement strategies that federal policymakers require federal agencies to offer states, through independent organizations, through discretionary grants to states and/or through increases in existing sources of funds to states.

Barriers to Quality Improvement

Even in states with state administrators devoted to quality improvement in infant child care, barriers to realizing this commitment impeded progress. These barriers, most of which still exist, include:

- the serious problems in the quality of child care services for three-to-five-year old children and the fact that school age care often takes priority when funds are limited;
- public ambivalence about infant child care, which may curb policymaker interest in any public investment in infant child care, including investment in quality improvement;
- lack of knowledge about the recent medical and developmental research findings that underscore the need for quality in infant child care;
- the acute shortage of infant child care services and the need to focus policy priorities on expansion of an affordable supply,
- insufficient federal and state financing to sustain, expand and improve infant child care services;
- varied levels of commitment in the governors' offices and in the state legislatures;
- isolation and lack of opportunity to plan collaborative financing and training strategies with other administrators in the same state;
- narrowly defined categorical federal funding, which does not lend itself to integration of services, segregates services young children and their families need, and creates high administrative costs at state and community levels;
- a policy climate of uncertainty about both state and federal regulation of child care (particularly family child care, a major source of care for infants and toddlers) as a principal way to assure safety and provide a base for quality;

- a lack of federal policymaker and general public understanding and valuing of the roles regulation, licensing and monitoring play in quality improvement;

- insufficient investment in the type of monitoring and data-based management systems that would enable state administrators to present an accurate assessment of results from quality improvement strategies (including the results of regulatory approaches);

- a pervasive view that child care is solely a work-enabling service for parents, which neglects its heavy influence on child development;

- the penchant for focusing the school "readiness" movement on four-year-old cognitive abilities and accomplishments rather than building readiness by fostering the social-emotional and healthy development of the infant and toddler;

- lack of knowledge at the federal and state level about policy and program practices that have proved effective in other states; and

- a federal climate that ranges from support through indifference to hostility toward state policymaker actions to sustain and improve quality.

Contributions of Goal-Directed Technical Assistance

Goal-directed technical assistance contributed to quality improvement in three ways. It facilitated:

(1) increased knowledge among state policymakers about recent federal policy developments, research findings and promising or proven approaches to improving quality in child care;

(2) increased interaction and/or policy planning among child care and other administrators concerned with the same population (e.g., early intervention and/or maternal and child health administrators); and

(3) improved quality assurance policies (both regulatory and nonregulatory).

BCTB's goal-directed technical assistance helped states make improvements in quality assurance policy areas that are:

- highly technical and therefore dependent on knowledgeable inputs, particularly in areas where new knowledge has been recently generated (e.g., health and safety requirements and training; use of computer technology in monitoring; or financing strategies that use new funding in little-known ways); and

- complex, but relatively low-cost and noncontroversial (e.g., improvement of licensing and monitoring practices; licensor training; expansion and improvement of caregiver training, especially career development-focused voluntary training).

BCTB's goal-directed technical assistance helped states make improvements in quality assurance policy by providing information about:

- workable models from other states;
- new ways of using or thinking about using existing state or federal funds (e.g., use of funds earmarked for improvements in quality assurance policies; creative use of federal open-ended entitlement funds);
- mandates and requirements that the federal government has enacted; and/or
- mandates and requirements that the state legislature has enacted.

Goal-directed technical assistance alone, however, cannot contribute in any major way to improvement of quality assurance policies that are necessary but are:

- considered too costly by policymakers and the populace of the state;
- considered too controversial by policymakers and the populace of the state; and/or
- completely outside the jurisdiction of the state administrator who serves as the principal liaison to the TA providers (e.g., integration of infant health services with infant child care, if the principal liaison is the child care administrator).

It is our considered conclusion that well-debated state and/or federal mandates are needed to instigate quality improvement in these instances. Goal-directed technical assistance, however, can help administrators to implement these mandates, after they have been enacted.

<u>Goal-directed technical assistance will be most effective when it:</u>

- involves state legislators as well as state administrators;
- is provided to states whose recent legislative as well as gubernatorial history has been well researched by the technical assistance team;

- is provided by skilled, knowledgeable and well-focused individuals who are able to maintain empathy for and positive relationships with state administrators caught in the "pincer" (between state government and the federal government), without losing sight of the goals of the project;

- continually takes a strategic planning approach to the organization and delivery of the technical assistance, that is, an approach that involves the setting of goals, objectives and strategies;

- continually assesses the goals, objectives and strategies and adapts them, when necessary;

- monitors federal developments so that state policymakers can be rapidly informed about them;

- monitors state legislative activities in that state so as to better understand the situation of the state legislators and administrators;

- meets state administrator needs and reduces or facilitates their work load; and

- addresses the role of state advocates and parents.

Nine Lessons Learned from the BCTB Project

1. The impact of goal-directed technical assistance may not be able to be evaluated using a quantitative approach.

The goals of goal-directed technical assistance may initially be those shared by the technical assistance provider and the state policymakers, but at the deepest level they are the goals of the state policymakers. Thus, the technical assistance provider must be willing to adapt the TA objectives and, if absolutely necessary, the TA goals, as major new developments in state or federal policy make it necessary for state policymakers to adapt their goals.

Consequently, goal-directed technical assistance, including that which is being independently evaluated for its outcomes, cannot adhere to one model (as might be the case in a more self-contained research project), without risking the loss of trust and/or respect of the state policymakers.

2. **A strong commitment from both state and federal policymakers is needed if separate funding streams are to be integrated at the state level. Federal and state policy should further encourage this.**

Using multiple sources of funding to improve the quality and comprehensiveness of infant and toddler child care services takes a strong commitment ("buy in") from each of the state administrators and some encouragement from federal administrators and policymakers to integrate resources in a logical manner.

State administrators for Part H (early intervention), Maternal and Child Health (Title V) and Medicaid are faced with federal categorical funding requirements and have had to respond to insufficient federal funding with increasingly complex work loads and/or mandates and the decreasing availability of state funding needed to draw down federal monies. Child care administrators in all fifty states and Tribal programs have had massive headaches in responding to federal proposed and interim regulations. However, in the states we are most familiar with, Utah, Illinois and Florida, the child care administrators have managed to combine most of the child care financial assistance funds. Very-low-income families in these states have access to a range of child care settings without regard to source of funds. Much more work, however, needs to be done to upgrade the choices of child care arrangements for employed families on AFDC and families on AFDC who are on the waiting list for the JOBS program. Federal and state policymakers should focus more on this issue.

3. **Trying to promote coordination through the governor's office is not always effective, given the real life role of the governor's office.**

We hoped that going through the governor's office would promote coordination among infant and toddler child care, child health and early intervention services. We learned that we had unrealistic expectations of the role of the governors' offices and that:

- the governors' offices have shifting priorities;
- a governor's office leadership in organizing coordination does not help unless the workload of state administrators is reduced in order to support their work on coordination;
- changes in governors causes shifts in the personnel and the priorities of state administrators; and
- the key state administrators should create the agendas for and attend the meetings at the governor's office in collaboration with the goal-directed technical assistance team.

4. **It is important to focus on areas of agreement and to work with administrators' strengths and interests.**

It is important to be flexible and:

- consistently be open to renegotiation of objectives while continuing to focus on the overall goal of quality improvement;
- secure sufficient "buy in";
- support state administrators' overall quality improvement goals and objectives; and
- whenever possible, do the work they need to support quality improvement.

5. **Expert knowledge and information should match state needs.**

Information should be made available in a variety of ways, including group discussions and individual phone and letter contacts. It should be easily understood and should focus on the child development needs of infants and toddlers in child care as well as other requested areas.

The role of the technical assistance provider in meetings needs to be clear (facilitator, leader or resource). Funding should be available to technical assistance providers or to states to bring administrators from the involved states together to learn from each other.

6. **Technical assistance information will be most effective to states when:**

- it illustrates the potential for quality improvement through blending funding sources;
- it describes successful models and strategies from other states/communities;
- it is research/practice based and is focused on the well-being of infants/toddlers/ their families and the state's system of policy supports to improve child care (training, regulations, licensing functions, consumer education, etc.);
- it supports the "political will" of state administrators, state legislators, child care leaders and governors to improve child care;
- there are enough funds to implement the desired changes; and
- it is tailored to meet the needs of state administrators as much as possible.

7. The use of negotiated, flexible technical assistance is important.

There is a need for a general, cohesive goal. Written letters of agreement are important to achieving common goals and/or objectives. The objectives a state chooses should fall under the goal but also be targeted to meet their particular needs.

Although crises do occur, requiring patience, understanding and flexibility (hurricanes, recessions, class action suits, etc.), it is paramount to spend time evolving the objectives with the participants. The process of drafting the letters of agreement is instructive to all.

8. Interagency collaboration is a demanding process that takes time, leadership and the commitment of all involved.

In the BCTB participating states, child care administrators were already coordinating (integrating) a variety of funding sources to help families, children and providers. This is a very time consuming and demanding process given the complexities of so much categorical funding. When collaboration is an objective that states use to achieve the goal of quality improvement, technical assistance providers need to become experts at fostering collaboration and be prepared to facilitate that process, if needed, with the strong endorsement of the state administrators.

State level improvement in the integration and comprehensiveness of infant-toddler child care and child health, would be enhanced if collaboration becomes a priority for all state team members. Federal administrators and congressional policymakers need to direct and support collaboration to make it happen. Bringing state administrators together from Medicaid/EPSDT, Part H, Maternal and Child Health and Welfare (with child care administrators) does not necessarily result in greater integration of services, if other demands on state administrator time or other pressing needs for state and federal funds impede integration.

The Child Care and Development Block Grant was the only major source of funds administered by a state team member that specifically required using a small amount of money to enhance the quality of services available to children in child care. The others can address quality and comprehensiveness only by shifting emphasis from an existing priority to another or by adding state funds and complying with extremely complex and inflexible Medicaid and welfare regulations.

9. **To improve child care for all infants and toddlers whose families receive welfare, it is imperative that not only the people in charge of Family Support Act child care be involved, but also those who make policy related to the child care income disregard program.**

Many families receiving AFDC use the child care income disregard to pay for care as they are working their way off welfare by holding low-wage and/or part-time jobs that supplement their AFDC grant. There are "caps" on these public funds and when they are intertwined with a parent's earnings and AFDC grant levels, the resulting amount of money available in their AFDC grant is usually so minimal that these infants and toddlers and their families can not afford care with even the most basic levels of consumer protection. Families who are eligible for the Family Support Act JOBS Program are more likely to receive consumer education on the supply and location of services, information on what to look for in quality care and how to make a complaint about child care. However, there are significantly more families who are employed and receiving AFDC, whose choices are limited to informal child care arrangements with no public oversight (rarely is there even a child abuse screening or criminal record check required). This is an area that technical assistance providers and state administrators need to isolate, elevate, integrate with and bring up to the same level as other child care services paid for with public funds (e.g., Head Start, CCDBG, and most other sources of funds used for non-relative child care and/or early education require some level of public oversight). This means getting to know the state's welfare agency operations. It is important to find out who sets funding levels (as the federal cap on the child care income disregard program can be supplemented), how the income disregard funding mechanism works, what is in the AFDC state plan, where to obtain the rules related to the program (and how to interpret them) and discuss the levels of consumer protection, access to quality and stability and consumer education available to these children and families in comparison to other children whose families receive child care financial assistance paid for by public funds.

The Better Care for the Babies Project developed and provided goal-directed technical assistance to three states, in an effort to help these states make policy improvements that would translate into improvements in caregiving practices. The following are the **ZERO TO THREE** BCTB Project's recommendations that stem from the lessons learned about the provision of technical assistance to states to improve the quality of infant and toddler child care services.

Six Recommendations

1. **Reauthorization (or changes in the current regulations) of the CCDBG, Title IV-A At-Risk Child Care Program and the Family Support Act needs to allow funding to be used for/or increase funding to allow:**

    - differential rates to reward higher levels of quality;
    - rates above the 75th percentile;
    - significant grantmaking and/or contracting for services as well as the use of vouchers/certificates;
    - higher spending levels for quality improvement;
    - increased training of child care providers and licensing staff and improvements in monitoring systems across each source of funds;
    - more collaboration and coordination among early childhood, child health, early intervention and family support services;
    - increased resource and referral services;
    - supplementing the income disregard rates for families on AFDC or Transitional Child Care to equal rates paid by other sources of federal or state funding;
    - administrative costs across each source of funds;
    - incentive grants to states to recruit unregulated child care providers paid with public funds to meet health, safety and other quality standards; and
    - incentives for Maternal and Child Health and Part H to incorporate training, consultation and preventive health education for parents and staff in the child care setting.

2. Federal mandates to states to improve quality are needed.

Much child and family policy change at the state level is the result of "pincer" action by state legislatures and the federal government (Connor, 1983; Hansan, 1983; Heintz, 1983).

Our experience corroborates the observations of the social scientists cited above. In the executive branches of state government (the governor's office and state administrative agencies), the decisions about quality improvement are strongly influenced by two factors: what the state legislature wants to see done or is willing to ratify as a condition for participation in federal financing, and what the federal government expects in return for those federal funds that the state wants.

If neither significant player requires quality improvement, only a highly unusual and highly committed group of state administrators can effect much quality improvement—and only in a state with a history of support from a strong governor who is committed to children's issues.

It is our belief that sensitively drawn, reasonable federal mandates that reflect a compromise won at the federal level after free and open debate help committed state officials accomplish objectives that are good for children and families—and motivate the less committed to accomplish at least some movement toward quality improvement.

What is needed is a balancing of: (1) the right of very vulnerable infants and toddlers (and their families) to be protected from physical or emotional harm that can come from participation in damaging child care (child care that is paid for with public funds) with (2) the rights of states to set their own policies, free from ineffective meddling by entities outside the state. Poorly developed mandates make it harder for states to protect vulnerable infants and toddlers and their families in child care.

States with a strong legislative history of support for good quality child care need federal mandates less, of course. For these states federal goals and incentives may suffice. However, federal mandates seem necessary for states whose legislators have a history of ignoring or overlooking the rights of parents and children to decent quality in child care. Otherwise, child death, injury, disease or long-term physical and/or developmental damage may result from poor quality care.

Finally, federal mandates cannot be implemented well unless the federal government supplies at least some of the funds needed to implement them. In principle, the federal government should supply federal funding matched by state funds to help states meet mandates.

3. **New types of federal mandates should be developed that take into consideration the new generation of state policymakers coming of age in state governments.**

It was our good fortune in BCTB to be able to observe the work of resourceful and committed state executive branch officials. We were also able to learn about state legislators with deep awareness of/support for quality improvement in child care.

What and whom to regulate are not easy policy questions to resolve, particularly for small child care facilities. A balanced approach would be for the federal government to agree on a few individual parent and child rights, regardless of where the family lives (such as the already legislated parent right of access to child care facilities). This could be coupled with federal mandates and funding to improve quality in certain agreed-on, federally specified regulatory areas (e.g., training, health and safety, coordination, etc.) in ways of the states' own choosing.

The focus would be on results: actual improvements in policy and program practice. The approaches that states use to realize these results would be decided by the states.

4. **Goal-directed technical assistance will be most effective when provided as a companion to these new types of broad, agreed-upon federal mandates and funds for quality improvement.**

Blending a federal expectation for quality improvement that includes federal tolerance for a high degree of autonomy on the part of the states with a healthy availability offering of goal-directed technical assistance may prove to be a useful companion approach to stimulating and supporting quality improvement. Providing technical assistance when states want to implement new mandates will work best.

Goal-directed technical assistance can help committed and resourceful state policymakers in the absence of mandates or money, when it stimulates and/or supports some steps toward quality improvement. However, policy goals at both the state and federal level are most likely to be reached when the broad goal of quality improvement in a few areas has been mandated and money is made available to fulfill this mandate. In crisis-ridden state governments, mandated activities take precedence over voluntary ones.

5. **Foundations, government entities and other funders who have supported programs and projects designed to improve practice in infant child care would have a greater impact if they also supported the technical assistance needed to bring these approaches to the personal attention of state policymakers, in a policymaker-friendly format.**

Projects that promote best practice in infant and toddler child care will be more useful if a technical assistance provider describes them to state policymakers in a personalized and understandable manner. Using technology to transfer key information on the influence child care services have on the development of infants and toddlers is important. However, the demands on state policymakers are such that this information can not just be sent to them. It should be brought to them in a personal way through the technical assistance provider, in a format useful to them.

6. **State policy and program coordination is most successful when there is a coordinator at the state level and a mandate to coordinate.**

In the absence of federal or state government mandates requiring state administrator interaction, goal-directed technical assistance (which requires interagency planning as one condition of participation) can mildly reduce the isolation of state child care administrators. Even mild reductions in the isolation of state child care administrators from other state administrators will stimulate positive policy change.

However, in this type of goal-oriented technical assistance, there is more likelihood of increased administrator interaction when there is a federal or state government mandate requiring state administrator interaction. A voluntary commitment to coordinate is not likely to suffice, as it usually takes a lower priority than activities mandated by state and/or federal laws.

This coordination will occur most effectively, however, when funds are also made available to support the work of a coordinator. We learned early in the project that states had insufficient funds even to support a state administrator part-time to coordinate cross agency collaboration related to BCTB. Our inability to provide such funds—along with information—impeded progress. Ultimately, state legislatures should provide funds to staff coordinating offices. In the interim, technical assistance projects may have to give states minigrants, if encouragement of coordination is one goal of the project.

From this effort, we have learned a great deal. We hope that our lessons learned will be useful to all who care about children and families—and who hope and work for a day when all caregivers will be better supported and infants, toddlers and parents who need quality child care will receive high-quality, whole-baby, family-centered child care.

APPENDIX A

Staff, Consultants and Advisors

Staff, consultants, advisors and board oversight

Until October 1991, the project staff consisted of **ZERO TO THREE**/NCCIP's Executive Director (Eleanor Szanton) for a few hours weekly; a project director part-time (Peggy Pizzo); one full-time deputy director (Deane Argenta); and one administrative assistant (Angel Love). In October 1991, a full-time co-director (Abbey Griffin) joined the project and in the fall of 1992, Helen Keith was hired as associate director.

The staff's principal expertise is in child care delivery system issues: federal policy related to child care and early intervention services for infants and toddlers, and infant and child development. The BCTB team also offers skills in evaluation and survey research, knowledge of current research; and the ability to translate research findings into policy language.

The work of the staff was enriched by four consultants:

- an expert in health and safety protections and the integration of the health and child care systems, Susan Aronson, M.D.
- an expert in child car delivery system issues, the improvement of regulation and the development of training for caregivers with a career development focus, Gwen Morgan, M.S.
- an expert in monitoring and evaluation of child care quality and a state administrator himself, Richard Fiene, Ph.D.
- an expert in legal issues related to and financing for health care, early intervention and other human services, David Chavkin, J.D.

Finally, the project's oversight was conducted by five members of **ZERO TO THREE**/ NCCIP's Board of Directors:

J. Ronald Lally, Ph.D.
Sally Provence, M.D.
Lynn Straus, M.S.
Bernice Weissbourd, M.S.
Edward F. Zigler, Ph.D

APPENDIX B

Samples of Technical Support Provided by the Better Care for the Babies (BCTB) Project

1. Technical assistance related to state policy development and infant/toddler child care.

   A. State policy development to assure or promote good program practices, based on research evidence and expert consensus and/or opinion—e.g.,

      (1) appropriate content of and approach to training for caregivers;

      (2) appropriate content of and approach to the regulation of infant child care; and

      (3) new strategies for expanding the supply of infant child care.

   B. State policy development to finance good program practices—e.g.,

      (1) The content of federal laws related to the provision of services to infants, authorized under:

         - Title IV-A of the Social Security Act (The Family Support Act);
         - Title XX of the Social Security Act (The Social Services Block Grant);
         - the 1990 Child Care and Development Block Grant Act;
         - the 1990 Child Care and Block Grant Act;
         - the 1990 Reauthorization of the Human Services Act (including the reauthorization of the Head Start Act);
         - Public Law 99-457 (The Education of the Handicapped Act), Part H; and
         - Title XIX of the Social Security Act (Medicaid).

2. Technical assistance related to possible public-private partnerships at the state level.

   A. The development of public/private partnerships that provide:

      (1) financing of in-state expertise to be made available to state government officials; and

      (2) published articles describing each state's work in national professional journals.

APPENDIX C

BCTB'S POLICY PAPERS AND BRIEFINGS, 1990—PRESENT

Whole Babies, Parents and Pieces of Funds: Creating Comprehensive Programs for Infants and Toddlers, **ZERO TO THREE**/NCCIP, Peggy Pizzo, M.Ed., January, 1990.

"Analysis of Child Care and Child Development Block Grant (CCDBG) and The Child Care At-Risk Program: Legislation," **ZERO TO THREE**/NCCIP, October 1990; and Regulations, BCTB staff, July, 1991.

State Regulations Concerning Toddlers in Child Care, **ZERO TO THREE**/NCCIP, Abbey Griffin, Ph.D., January, 1991.

Head Start and Medicaid, National Head Start Association Journal, David Chavkin, J.D. and Peggy Daly Pizzo, M.Ed., Spring, 1991.

"Side-by-Side Analysis of State Allocations of Child Care and Development Block Grant Funds: Reserving Funds For Quality Improvement," **ZERO TO THREE**/NCCIP, BCTB staff, February, 1992.

"Implications of the Americans with Disabilities Act (ADA) for Child Care Services," briefing packet, **ZERO TO THREE**/NCCIP, BCTB staff, February, 1992.

"Health and Safety Risks and Family/Group Child Care Homes with Large Group Sizes and Too Many Infants and Toddlers," BCTB staff, March, 1992.

Medicaid and Child Care: Good Partnership Potential, **ZERO TO THREE**/NCCIP, David Chavkin, J.D. and Peggy Daly Pizzo, M.Ed., Young Children, March, 1992.

Promoting Change in State Policy Decisionmaking on Quality Infant/Toddler Child Care and Head Start Services: Study of a Technical Assistance Forum, **ZERO TO THREE**/ NCCIP, Abbey Griffin, Ph.D. and Richard Fiene, Ph.D., September, 1992.

Financing Family-Centered Infant Child Care, **ZERO TO THREE**/NCCIP, Peggy Daly Pizzo, M.Ed., October, 1992.

"Financing Opportunities and Models through Title V and Part H, IDEA," BCTB staff, 1992.

Preventing Preventable Harm to Babies: Promoting Health and Safety in Infant/Toddler Child Care, **ZERO TO THREE**/NCCIP, Abbey Griffin, Ph.D., March, 1993.

Caring for Mildly Ill Infants and Toddlers in the Context of Child Care: Emotional, Medical and Practical Perspectives, Zero to Three, **ZERO TO THREE**/NCCIP, March, 1993.

Lessons Learned: Provision of Technical Assistance to States, Better Care for the Babies Project, **ZERO TO THREE**/NCCIP, Peggy Pizzo, M.Ed., Abbey Griffin, Ph.D., Helen Keith, Deane Argenta, M.S., & Eleanor Stokes Szanton, Ph.D., projected publication date, April, 1993.

Not Mother, Not Teacher: Essential Practices and Special Challenges in Developing State Training Plans for Infant and Toddler Caregivers, **ZERO TO THREE**/NCCIP, Abbey Griffin, Ph.D. (in progress).

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